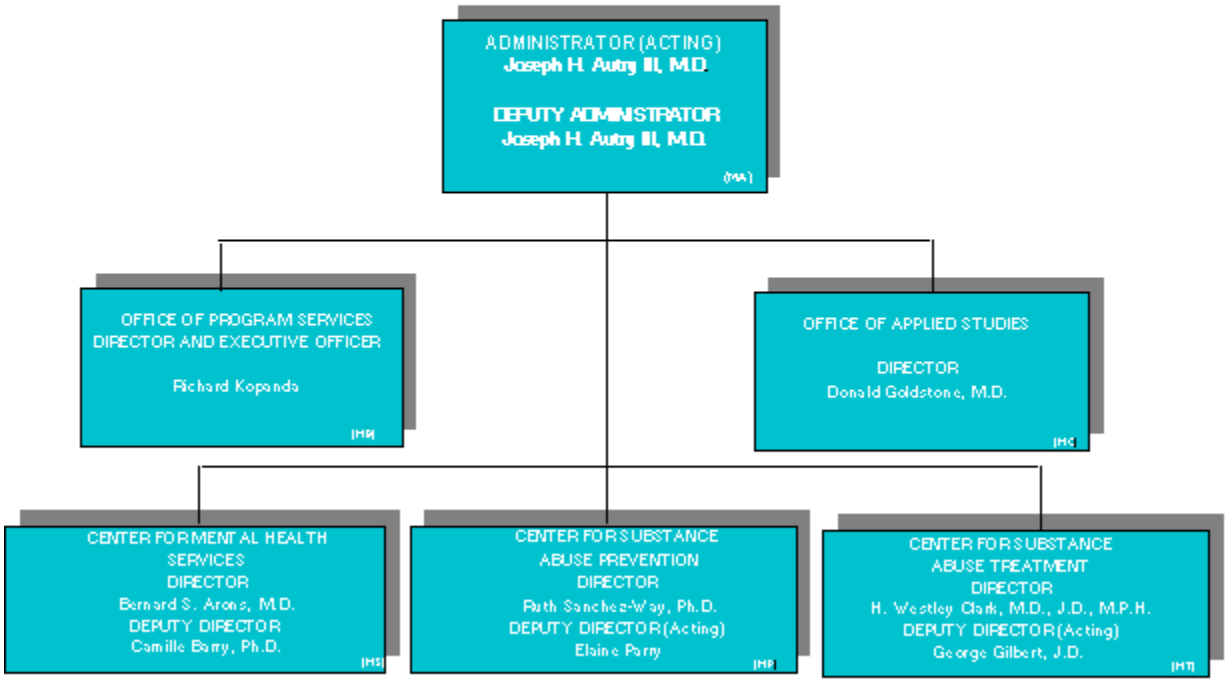
DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Fiscal Year 2002 Budget **Page**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration



Substance Abuse and Mental Health Services Administration

Appropriation Language

For carrying out titles V and XIX of the Public Health Service Act with respect to substance abuse and mental health services, the Protection and Advocacy for Mentally Ill Individuals Act of 1986, and section 301 of the Public Health Service Act with respect to program management, [$2,958,001,000] $3,029,456,000 [of which $24,605,000 shall be available for the projects and in the amounts specified in the statement of the managers on the conference report accompanying this Act.][1] *Provided, That in addition to amounts provided herein, $29,000,000 shall be available under section 241 of the Public Health Service Act, to carry out national data collection activities.*[2] *(Departments of Labor, Health and Human Services, and Education, and related Agencies Appropriation Act, 2001, as enacted by section 1(a)(1) of P.L. 106-554.)*

Explanation of Language Changes

[1] One year projects earmarked by the Congress in FY 2001 are not continued in FY 2002.

[2] Similar to other agencies of the Department of Health and Human Services, funds will be directly appropriated to SAMHSA from the Secretary's PHS one percent evaluation fund to carry out national data activities important for program evaluation.

Substance Abuse and Mental Health Services Administration

Amounts Available for Obligation

	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate
Appropriation:			
Labor/HHS-Annual	$2,654,953,000	$2,958,000,000	$3,029,456,000
Recission P.L. 106-554	—	($645,000)	—
Subtotal, adjusted budget authority	2,654,953,000	$2,957,356,000	3,029,456,000
Transferred to Other Accounts	(527,838)	—	—
Rescission P.L. 106-113	(3,085,000)	—	—
Unobligated balance expiring	(1,643,720)	—	—
Offsetting Collections from: Federal Sources	32,505,210	40,000,000	69,000,000
Total obligations	$2,682,201,652	$2,997,356,000	$3,098,456,000

Substance Abuse and Mental Health Services Administration
Summary of Changes

2002 Estimate	$3,029,456,000
2001 Current Estimate	-2,957,356,000
Net Change	+$72,100,000

	FY 2001 Current Estimate		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Annualization of 2001 pay costs	--	$50,182,000	--	+$464,000
2. Within grade pay increases	--	50,182,000	--	+903,000
3. Increase for January 2002 pay raise at 3.6%	--	50,182,000	--	+1,355,000
4. Increase for one more day of pay in 2002	--	50,182,000	--	+192,000
5. Increased rental payments to GSA	--	4,522,000	--	+209,000
6. Increase in overhead charges	--	12,469,000	--	+524,000
Subtotal, Built-in Increases	--	---	--	+3,647,000
B. Program:				
1. Substance Abuse Programs of Regional and National Significance (Targeted Capacity Exp.)	--	256,122,000	--	+40,000,000
2. Substance Abuse Block Grant	--	1,665,000,000	--	+60,000,000
Subtotal, Program Increases	--	---	--	+100,000,000
Total Increases	--	---	--	+103,647,000
Decreases:				
A. Built-in:				
1. Mental Health Programs of Regional and National Significance (PRNS):				
a. Reduction for earmarked projects funded in FY 2001 for one year	--	203,499,000	--	-10,900,000
b. PRNS program reduction	--	203,499,000	--	-5,000,000
Subtotal, PRNS	--	---	--	-15,900,000
2. Program Management:				
a. Reduction for earmarked project funded in FY 2001 for one year	--	67,173,000	--	-3,278,000
b. Reduction in operating costs	--	67,173,000	--	-369,000
Subtotal, Program Management	--	---	--	-3,647,000
B. Program Management:				
1. Decreased funding for the National Household Survey on Drug Abuse; funds will be derived from the 1% evaluation resources	--	12,000,000	--	-12,000,000
Subtotal, Program Management Decreases	--	---	--	-12,000,000
Total Decreases	--	---	--	-31,547,000
Net Change, SAMHSA Discretionary BA	--	---	--	+$72,100,000

Substance Abuse and Mental Health Services Administration
Budget Authority by Activity
(Dollars in thousands)

Program Activity	FY 2000 Actual	FY 2001 Appropriation	FY 2001 Current Estimate	1/	FY 2002 Estimate	Increase/ Decrease
Programs of Regional and National Significance	$497,828	$635,134	$634,634		$658,734	+$24,100
Mental Health (Non-add)	*(136,733)*	*(203,674)*	*(203,499)*		*(187,599)*	*(-15,900)*
Substance Abuse Prevention (Non-add)	*(146,705)*	*(175,145)*	*(175,013)*		*(175,013)*	*(---)*
Substance Abuse Treatment (Non-add)	*(214,390)*	*(256,315)*	*(256,122)*		*(296,122)*	*(+40,000)*
Children's Mental Health Services	82,677	91,763	91,694		91,694	---
Protection & Advocacy	24,903	30,000	30,000		30,000	---
PATH Formula Grant	30,883	36,883	36,855		36,855	---
Mental Health Block Grant	356,000	420,000	420,000		420,000	---
Substance Abuse Block Grant	1,600,000	1,665,000	1,665,000		1,725,000	+60,000
Program Management	59,049	79,221	79,173	2/	67,173	-12,000
TOTAL, SAMHSA Discretionary BA	2,651,340	2,958,001	2,957,356		3,029,456	+72,100
Data Collection (1% Evaluation)	---	---	---		29,000	+29,000
TOTAL, SAMHSA Program Level	$2,651,340	$2,958,001	$2,957,356		$3,058,456	+$101,100

1/ The FY 2001 amounts have been reduced as part of the Labor /HHS/Education FY 2001 administrative reduction.

2/ The appropriation includes $12 million for the National Household Survey on Drug Abuse in Program Management.

FY 2002 BUDGET SUBMISSION
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2001 Appropriation	FY 2002 Estimate	Increase/ Decrease
Direct Obligations			
Personnel Compensation:			
Full Time Permanent (11.1)	$39,020	$41,290	+$2,270
Other than Full-Time Permanent (11.3)	1,306	1,381	+75
Other Personnel Compensation (11.5)	1,269	1,342	+73
Subtotal, Personnel Compensation	**41,595**	**44,013**	**+2,418**
Civilian Personnel Benefits (12.1)	8,587	9,083	+496
Subtotal, Pay Costs	**50,182**	**53,096**	**+2,914**
Travel (21.0)	1,642	1,676	+34
Transportation of Things (22.0)	87	89	+2
Rentals to GSA (23.1)	5,914	6,123	+209
Rental Payments to Others (23.2)	20	20	—
Communications, Utilities and Misc. Charges (23.3)	1,890	1,930	+40
Printing and Reproduction (24.0)	3,939	4,022	+83
Consulting Services (25.1)	14,402	15,444	1,042
Other Services (25.2)	175,405	180,405	+5,000
Purchase from Gov't Accounts (25.3)	79,206	81,785	+2,579
Subtotal, Other Contractual Services (25.0)	269,013	277,634	+8,621
Supplies and Materials (26.0)	7,448	7,604	+156
Equipment (31.0)	1,097	1,120	+23
Grants, Subsidies, and Contributions (41.0)	2,614,457	2,674,440	+59,983
Insurance Claims & Indemnities	1,667	1,702	+35
Subtotal Non-Pay Costs	**2,907,174**	**2,976,360**	**+69,186**
Total Direct Obligations	**$2,957,356**	**$3,029,456**	**+$72,100**

FY 2002 BUDGET SUBMISSION
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SALARIES AND EXPENSES
(Dollars in Thousands)

Object Class	FY 2001 Appropriation	FY 2002 Estimate	Increase/ Decrease
Personnel Compensation:			
Full Time Permanent (11.1).....	$39,020	$41,290	+$2,270
Other than Full-Time Permanent (11.3).....	1,306	1,381	+75
Other Personnel Compensation (11.5).....	1,269	1,342	+73
Subtotal, Personnel Compensation	**41,595**	**44,013**	**+2,418**
Civilian Personnel Benefits (12.1).....	8,587	9,083	+496
Subtotal, Pay Costs	**50,182**	**53,096**	**+2,914**
Travel (21.0).....	1,642	1,676	+34
Transportation of Things (22.0).....	87	89	+2
Rental Payments to Others (23.2).....	20	20	---
Communications, Utilities and Misc. Charges (23.3).....	1,890	1,930	+40
Printing and Reproduction (24.0).....	3,939	4,022	+83
Other Contractual Services:			
Consulting Services (25.1).....	11,002	11,233	+231
Other Services (25.2).....	35,518	38,382	+2,864
Purchases from Gov't Accounts (25.3).....	9,044	11,623	+2,579
Subtotal, Other Contractual Services (25.0)	**55,564**	**61,238**	**+5,674**
Supplies and Materials (26.0).....	7,448	7,604	+156
Subtotal Non-Pay Costs	**70,590**	**76,579**	**+5,989**
Total Salaries and Expenses	**$120,772**	**$129,675**	**+$8,903**

Significant Items for the House, Senate, and Conference Appropriations Committee Reports

FY 2001 House Report No. 106-645

Item: Minority Fellowship program -- The Committee recognizes the role that the Minority Fellowship program plays in training mental health professionals to provide services to individuals who would otherwise go untreated and urges SAMHSA to enhance its efforts in this program through its three Centers. (Page 99)

Action Taken or to be Taken

In FY 2001, SAMHSA will provide an increase of $2 million for the Minority Fellowship Program.

Item: CMHS and Justice collaboration --. . . . The Committee encourages SAMHSA to assist local jurisdictions, in collaboration with States, to apply current knowledge about effective interventions to meet the needs of adults with serious mental illness who come in contact with the criminal justice system. CMHS is encouraged to work collaboratively with the Bureau of Justice Assistance at the Department of Justice. (Page 99)

Action Taken or to be Taken

SAMHSA is working with the Corrections Program Office within the Bureau of Justice Assistance and is funding a portion of their re-entry program. This program provides services to adults with serious mental illness who are departing the justice system.

Item: Suicide --. . . . The Committee urges CMHS to strengthen community-based organizations and other entities that provide innovative and culturally sensitive treatment and prevention services to address the issue of teen suicide through interventions and support services to those individuals who are at risk. (Page 99)

Action Taken or to be Taken

In FY 2000, CMHS awarded four Youth Suicide Cooperative Agreements to community based organizations to promote the prevention of youth suicide. The goals of these grants are to build community-wide understanding of youth suicide, to build real and sustainable community-wide collaborations to address this public health crisis, and to implement and sustain evidence-based youth and family service programs.

Item: Substance Abuse Services for the Homeless -- The Committee is concerned that Federal resources may not be reaching hard-to-serve populations, like the homeless, and therefore has provided $10,000,000 to initiate grants to local non-profit and public entities for the purpose of developing and expanding substance abuse services for the homeless. (Page 101)

Action Taken or to be Taken

In FY 2001, SAMHSA will support projects to help communities address drug and alcohol problems among homeless individuals by providing effective interventions. It is expected that 18-20 new awards will be made with these funds.

Item: Substance Abuse Block Grant -- The Committee has modified bill language that was included in the fiscal year 2000 appropriations bill to distribute the block grant funding to the States so that no State's funding is reduced below the fiscal year 2000 level. (Page 101)

Action Taken or to be Taken

This directive has been implemented, and no State's funding in FY 2001 was reduced below the FY 2000 funding level.

Significant Items for the House, Senate, and Conference Appropriations Committee Reports

FY 2001 Senate Report No. 106-293

Item: Targeted capacity expansion -- The Committee agrees with the President's request to establish new targeted capacity expansion line items in the areas of substance abuse prevention and treatment. (Page 184)

Action Taken or to be Taken

Targeted Capacity Expansion grants will be awarded to municipal, county, State and tribal governments to provide prevention services and help close the gap in treatment for emerging substance abuse problems. These programs are intended to ensure that individuals with substance abuse problems can access services employing the best practices proven to be effective.

Item: Substance abuse in rural and native communities -- The Committee remains concerned by the disproportionate presence of substance abuse in rural and native communities, particularly for American Indian, Alaska Native, and native Hawaiian communities. The Committee reiterates its belief that funds for prevention and treatment programs should be targeted to those persons and communities most in need of service. Therefore, the Committee has provided sufficient funds to fund projects to increase knowledge about effective ways to deliver services to rural and native communities. Within the funds reserved for rural programs, the Committee intends that $8,000,000 be reserved for CSAP grants, and $12,000,000 be reserved for CSAT grants. (Page 184)

Action Taken or to be Taken

CSAP has earmarked $8.0 million in funds to support substance abuse prevention efforts in rural and native communities. These funds supported both new and continuing efforts in FY 2000. These programs will be continued in FY 2001.

In FY 2000, CSAT provided approximately $21.5 million in funds to increase knowledge about effective ways to deliver services to rural and native communities. It is expected that those programs will continue in FY 2001 and that additional efforts will be initiated to increase knowledge about effective ways to deliver services to rural and native communities. For example, CSAT plans to fund American Indian/Native Alaskan planning grants targeted toward those communities and tribes where the need for drug abuse treatment exists, but where no treatment available. It is expected that $1 million will fund 8-10 planning grants in FY 2001.

Item: Service Delivery -- The Committee notes that Alaska has the highest rate of alcohol dependency in the Nation, the highest rate of suicide, and the highest rate of child abuse, especially in Native communities in Alaska. The Committee urges the agency to work with the Alaska Federation of Natives in consultation with the State of Alaska to identify the most effective service delivery practices and develop model programs for implementation in the Alaska Native community. (Page 185)

Action Taken or to be Taken

In FY 2000, SAMHSA (CSAT, CSAP) partnered with the State of Alaska to develop prevention and treatment strategies to reduce the number of children affected by Fetal Alcohol Syndrome. In FY 1999, SAMHSA (CSAT, CMHS) partnered with the State of Alaska on the Anchorage Comorbidity Services project which is designed to develop, implement and evaluate a comprehensive, seamless system of care for persons with co-occurring substance abuse and mental health disorders. Both of these programs, as well as others providing services within the State of Alaska, will continue in FY 2001 in order to identify and implement model programs in the Alaska Native community. SAMHSA (CSAT) also plans to award new funds to the Alaska Federation of Natives to identify best substance abuse treatment practices.

Item: School Violence -- The Committee has included funding for mental health counselors for school-age children, as part of an effort to reduce school violence. The Committee intends that $90,000,000 be used for counseling services for school-age youth. (Page 185)

Action Taken or to be Taken

In FY 2001, CMHS will continue the Safe Schools/Healthy Students Program. This unprecedented violence prevention collaborative effort started in FY 1999 is a major component of CMHS' youth violence prevention effort. This program supports: (1) screening and assessment in the school setting; (2) appropriate, scientifically-tested school-based mental health prevention and early intervention services for at-risk children; and, (3) referral and follow-up with local public mental health agencies for school age youth when indicated, consistent with the written agreement between the schools and the local public mental health organization. Treatment activities address the hiring of providers, e.g., school psychologists, and the specific preventive and treatment interventions these providers will use, if necessary.

Item: Interdisciplinary health professions training -- The Committee is pleased with the successful collaboration between the Center for Mental Health Services and the Bureau of Health Professions in HRSA to fund interdisciplinary health professions training projects, including training of behavioral and mental health professionals, for practice in managed care/primary care settings and urges that this joint effort be continued. The Committee encourages both agencies to develop technical assistance for use in health professions training programs for the purpose of enhancing primary care interdisciplinary models of practice. These efforts should be focused upon rural native populations that are at-risk for the problems most encountered by these health professionals. (Page 185-186)

Action Taken or to be Taken

The joint project of SAMHSA and HRSA's Bureau of Health Professions on Managed Behavioral Care and Primary Care has contracted with 4 professional associations. "Training protocols" linking training programs and primary health care facilities will be implemented. The SAMHSA Program; Aging, Mental/Health/Substance Abuse (MH/SA) & Primary Care has the active participation of HRSA's Bureau of Primary Health Care and has a training needs assessment to assure quality of MH/SA services for older adults through primary care. In FY 2001, best practices for integrated systems and required training models, will be identified both for the training of behavioral health

professionals in primary care settings, and the training of primary care professionals in behavioral disorders.

Item: Safe Schools/Healthy Students initiative -- The Committee applauds the interagency partnership to form the Safe Schools/Healthy Students initiative and encourages the Departments of Health and Human Services, Justice, and Education to continue working together to develop empirically-supported programs to prevent youth violence and to intervene with families, schools, and communities where violence has already occurred. (Page 186)

Action Taken or to be Taken

The Departments of Health and Human Services, Justice, and Education and now joined by the Department of Labor for FY 2001 will continue their interagency partnership and will continue to fund the empirically-supported programs to prevent youth violence and to intervene with families, schools, and communities where violence has already occurred. This interagency team is currently working on a new grant announcement for FY 2001.

Item: Concord Assabet Family and Adolescent Services -- The Committee is aware that Concord Assabet Family and Adolescent Services is committed to finding successful models that meet the special education, vocational training, and mental health needs of youth who are making the transition from institutional living arrangements to independent living. Development of these models is a key means of strengthening our communities by breaking the cycles of violence, poverty, and neglect suffered by many youth with mental disabilities. (Page 186)

Action Taken or to be Taken

In FY 2001, CMHS will award funds to Concord Assabet Family and Adolescent Services to be used to find model transitional living programs for troubled youth.

Item: Mental Health Intervention Programs -- The Committee is aware of the successful history of early intervention programs, especially for those programs reaching preschool-aged children. The Committee commends the National Preschool Anger Management Project for its development of the national "What Do You Do with the Mad that You Feel?" program, a 2\1/2\ hour workshop that educates teachers, at all levels, on the emotional development of a child's self-control. The workshop trains teachers on ways to support children's growth in basic skills of self-control and ways to intervene and re-direct when children have lost control. The Anger Management Project has facilitated teachers to help children manage their frustration and anger, which ultimately prevents the progression to violent acts. The Committee understands that the National Preschool Anger Management Project plans to disseminate materials nationwide and conduct training programs in communities in Pennsylvania, Illinois, Mississippi, Wisconsin, Ohio, Florida, Iowa, and Massachusetts. (Page 186)

Action Taken or to be Taken

In FY 2001, CMHS has requested that *Family Communications, Inc.* apply for a SAMHSA grant to disseminate Pre-School Anger Management training protocol intended to train day care providers who work with pre-school children.

Item: Mental health knowledge development and application -- The Committee is aware of the Texas Medication Algorithm Project (TMAP) and the benefit it has demonstrated in improving the quality of care for individuals who are prescribed psychiatric medications. This disease management program for people with serious mental illness synthesizes scientific and practitioner consensus into a practical guideline for physicians. Since many States have expressed interest in adopting the TMAP program in their States, the Committee urges the Administration to explore ways to support and facilitate that process, including the establishment of a technical assistance center on mental health best practices that focuses on best practices development, implementation, and evaluation. (Page 186)

Action Taken or to be Taken

The Center for Mental Health Services (CMHS) has supported the development of the Texas Medication Algorithm Project and recognizes the effect that the Project has had on improving the quality of patient care in the Texas public mental health system. Currently, SAMHSA has a contract with TMAP to support technical assistance on schizophrenia and depression algorithms in a minimum of three States.

Item: Mental health knowledge development and application -- The Committee is aware of efforts undertaken by the City of Lynn, Massachusetts to provide intensive counseling, evaluation, and investigation to children and adolescents who set fires, in recognition of the direct link that has been established between fire setting and sexual, physical, and mental abuse. The modest federal support sought by the city would enable it to expand this collaborative program to the region and develop a model for protecting both children and the communities. (Page 186)

Action Taken or to be Taken

The community mental health center in Lynn, Massachusetts utilizes Mental Health Block Grant funds to provide mental health services to children with serious emotional disturbances. CMHS is currently assessing their need for additional assistance.

Item: Mental health knowledge development and application -- The Committee is concerned that trauma system doctors and nurses are not prepared to help family members of trauma victims cope with the shock of unexpected death or critical injury. The Committee commends the American Trauma Society for designing a training program in response to this need and believes that SAMHSA should work with HRSA and the American Trauma Society to support the implementation of this program. (Page 187)

Action Taken or to be Taken

In FY 2001, CMHS has requested the American Trauma Society to apply for a SAMHSA grant to support the teaching and training of emergency personnel to help families cope with death, acute injury, or acute illness.

Item: Mental health knowledge development and application -- The Committee understands that many families in rural areas are suffering emotional and psychological distress in the wake of the recent farm crisis. The Committee is aware that the Farm Partners Project plans to provide mental health and stress management outreach programs for farmers in South Central Kentucky. The Committee also supports additional funding for Iowa State University Extension to develop a program that will provide outreach, counseling services, and training to mental health providers in rural areas. (Page 187)

Action Taken or to be Taken

In FY 2001, CMHS has requested the Iowa State Extension apply for a SAMHSA grant to support its services in rural areas.

Item: Mental health knowledge development and application -- The Committee recognizes the efforts of Chicago's Lakefront SRO, Northwest, and Lake County PADS to conduct a metropolitan-wide demonstration project known as Break the Cycle of Homelessness. (Page 187)

Action Taken or to be Taken

In FY 2001, CMHS has requested that United Power for Action and Justice apply for a SAMHSA grant to conduct a demonstration project in the Chicago land area.

Item: Mental health knowledge development and application -- The Committee understands that the Ch'ghutsen program plans to provide comprehensive mental health services for children in the interior of Alaska through a joint project with Tanana Chiefs Conference and Fairbanks Native Association. (Page 187)

Action Taken or to be Taken

In FY 2001, CMHS has requested that the Ch'ghutsen program apply for a SAMHSA grant to provide comprehensive mental health services for children in the interior of Alaska.

Item: Mental health knowledge development and application -- The recently released Surgeon General's Report on Mental Health affirmed the need to improve the mental health services available to older adults. The Committee believes that the Center for Mental Health Services should explore ways to enhance older Americans' access to mental health services, including assessing the number of older adults that are served under the mental health block grant and how States may better serve the unique needs of older adults. (Page 187)

Action Taken or to be Taken

In FY 2001, CMHS is continuing to plan ways to best serve the mental health needs of older adults. HRSA's Bureau of Primary Health Care jointly supported CMHS expanding this project to be a three year contract to include the Southeast States, and to include Substance Abuse in addition to primary care, mental health, and aging.

Item: Mental health knowledge development and application -- The Committee is aware of the California School of Psychology's efforts to initiate a project to demonstrate ways to more effectively provide behavioral and mental health services to the prison population of California. (Page 187)

Action Taken or to be Taken

In FY 2001, CMHS has requested that the Ventura County Sheriff's office of California apply for a SAMHSA grant to provide a mental health court and behavioral health series to criminal justice populations in Ventura county. In addition, current grantees of the Community Action Grant Program have had several examples of successful implementations of jail diversion and re-entry programs in other states.

Item: Mental health knowledge development and application -- The Committee believes that CMHS could more closely collaborate with the National Institute of Mental Health in order to maximize the benefits of activities conducted by both agencies. The Committee acknowledges that CMHS and NIMH could work together to identify research priorities, disseminate research findings, and develop tools to help communities use those findings to develop and improves services for adults and children with or at risk of developing mental health problems. (Page 187)

Action Taken or to be Taken

CMHS and NIMH staff are actively discussing a variety of proposals to better coordinate the development of research agendas and to share findings in topic areas of mutual endeavor. In addition, NIMH recently issued a program announcement soliciting applications for NIMH grants to study the effectiveness of child treatment interventionism community settings. The announcement requires that applicants conduct their studies at one of the CMHS Community Mental Health Services for Children and their Families Program grant sites. This collaboration should enhance our knowledge about the effectiveness of clinical services while enhancing service capacity in the grant sites. Finally, NIMH and CMHS staff sit on each other's advisory councils. The Director of the CMHS Division of Knowledge Development and System Change has joined the NIMH council and is pursing a collaboration agenda.

Item: Mental health knowledge development and application -- The Committee urges that SAMHSA develop, in cooperation with HRSA, training materials and resources related to depression and anxiety assessment and intervention for distribution and use by the State partners of CMHS and CSAT. (Page 187)

Action Taken or to be Taken

SAMHSA, HRSA, the Department of Veterans Affairs, and HCFA are collaborating on a multi-site study evaluating the effectiveness of various primary care responses to the needs of elders with psychiatric and substance abuse problems. Training materials and resources developed as a consequence of this collaborative study will be made available to State mental health and substance abuse partners through block grant programs and technical assistance centers.

Item: Mental health knowledge development and application -- The Committee recognizes the crucial role that the Minority Fellowship Program plays in training mental health professionals to provide services to individuals who would otherwise go untreated. The Committee encourages SAMHSA to increase its effort in this area. (Page 187)

Action Taken or to be Taken

In FY 2001, SAMHSA will provide an increase of $2 million for the Minority Fellowship Program.

Item: Mental health knowledge development and application -- The Committee understands that prevention and early intervention can reduce the need for more intensive services in certain individuals. For this reason, the Committee believes that CMHS [Center for Mental Health Services] could develop and implement empirically-based models for mental health prevention. Prevention and early intervention services could be carried out in collaboration with the Administration for Children and Families. (Page 188)

Action Taken or to be Taken

CMHS is committed to fostering the prevention of mental disorders and the promotion of mental health through rigorous services research. Progress in prevention science strategies and methods has relevance for all fields of public health and a collaboration with the Administration for Children and Families would be a relevant partnership. The Center for Mental Health Services will continue to develop and implement empirically-based models for mental health prevention, and is taking steps to collaborate on prevention and early intervention services with the Administration for Children and Families.

Item: Co-occurring disorders – The Committee is aware of a proposal by the Life Quest Community Mental Health Center to develop a program of treatment for co-occurring disorders for severely and persistently mentally ill, severely emotionally disturbed adults and children in the Mat-Su Valley region of Alaska. The Center, which serves a population of over 56,000, seeks to meet the currently unaddressed need to provide a comprehensive range of treatment for the increasing number of patients presenting with co-occurring disorders including chemical and substance abuse, severe depression and severe mental illness. (Page 188)

Action Taken or to be Taken

In FY 2001, CMHS has requested that Life Quest Community Mental Health Center apply for a SAMHSA grant to develop a program to treat mentally ill adults and severely emotionally disturbed children.

Item: Suicide, Fetal Alcohol Syndrome -- The Committee understands that Alaska Native children commit suicide at the highest rate in the nation and suffer disproportionately from behavioral and mental disorders, some caused by fetal alcohol syndrome. The Committee recommends that the agency work with the Alaska and the Alaska Federation of Natives, in consultation with the State of Alaska, to develop integrated systems of community care for these disorders. (Page 188)

Action Taken or to be Taken

In FY 2001, CMHS has requested that the Alaska Federation of Natives apply for a SAMHSA grant to implement integrated community care to treat Native Alaskan children with mental health disorders. In FY 2000, CSAT and CSAP partnered with the State of Alaska to develop prevention and strategies to reduce the number of children affected by Fetal Alcohol Syndrome. This program, designed to develop integrated systems of care, will continue in FY 2001. CSAT also plans to award new funds for the Alaska Federation of Natives to identify best substance abuse treatment practices.

Item: Mental health services to the homeless -- The Committee notes that Anchorage, Alaska has a number of individuals, particularly Alaska Natives, suffering from severe mental illness and substance abuse disorders who are also homeless. The Committee encourages the agency to work with the State of Alaska and the Alaska Federation of Natives to develop a plan for outreach, screening and diagnostic treatment services, rehabilitation, mental health services, alcohol or drug treatment, training and case management. (Page 188)

Action Taken or to be Taken

Through the Projects for Assistance in Transition from Homelessness (PATH) formula grant program, SAMHSA has provided Alaska with funding for services to persons who are homeless and have serious mental illnesses. Alaska is using these funds for outreach, screening and diagnostic treatment, community mental health services, alcohol and drug abuse support services, case management and referrals for housing and other services. These services are provided in Anchorage by the Crossover House Homeless Project of Anchorage Community Mental Health Services, Inc. (the largest community mental health center in Alaska). In FY 2001, CMHS has requested that the Alaska Federation of Natives apply for a SAMHSA grant to support the development of a plan to provide the array of services needed by homeless persons, especially Alaska Natives, who have serious mental illnesses and substance use disorders.

In FY 1999, CSAT and CMHS funded the Anchorage Comorbidity Services project, designed to develop, implement and evaluate a comprehensive, seamless system of care for persons with co-occurring substance abuse and mental health disorders. This program will continue in FY 2001. In addition, CSAT plans to fund projects to help communities address drug and alcohol problems among

homeless individuals under the Addictions Treatment for the Homeless program. CSAT also plans to award new funds for the Alaska Federation of Natives to identify best substance abuse treatment practices.

Item: AIDS Training Program grants -- The Committee is aware of the need for more trained health providers, including allied health professionals and social workers, to work with people suffering from HIV/AIDS. To the extent that funds are available, the Committee encourages SAMHSA to continue funding existing grants and contracts approved by SAMHSA under the current AIDS Training Program. (Page 188)

Action Taken or to be Taken

The Center for Mental Health Services will be initiating a direct services program that will support community-based efforts to provide direct mental health services for people living with HIV/AIDS, especially people of color. This direct services program will have a training component that targets both traditional and nontraditional mental health care providers, and will target primarily the needs of people of color.

Item: Minority Fellowship Program -- The Committee recognizes the crucial role that the Minority Fellowship Program plays in training mental health professionals in providing mental health services for people who often fail to seek services. (Page 188)

Action Taken or to be Taken

In FY 2001, SAMHSA will provide an increase of $2 million for the Minority Fellowship Program.

Item: Mental Health AIDS demonstrations -- This program provides grants to public and nonprofit private organizations to provide innovative mental health services to individuals who are experiencing severe psychological distress and other psychological sequelae as a result of infection with HIV. One coordinating center is supported to independently evaluate the quality and effectiveness of these services. The Committee commends the Center for Mental Health Services for its commitment in disseminating knowledge gained from these demonstration projects. The Committee urges the center to maintain its support for projects that provide direct mental health services while at the same time using the findings from previous projects to develop new knowledge in this area. The Committee again commends CMHS for its leadership in working cooperatively in demonstrating the efficacy of delivering mental health services to individuals affected by and living with HIV/AIDS. The Committee encourages the Secretary to maintain these agencies' support for this program. (Page 189)

Action Taken or to be Taken

The Center for Mental Health Services will continue to support the HIV/AIDS Treatment Adherence, Health Outcomes and Associated Cost Study, the multi-agency collaborative effort that followed the HIV/AIDS Mental Health Services Demonstration Program.

Item: Improper restraints and seclusion of mental health patients -- The Committee is aware that patients with mental illnesses have died or received life-threatening injuries in treatment facilities because of improper restraints and seclusion. The Committee has provided resources for protection and advocacy so that these deaths can be investigated and future incidences can be prevented. (Page 190)

Action Taken or to be Taken

The FY 2001 budget and new legislative requirements from PL 106-310, Child Health Act of 2000, for seclusion and restraint will provide State protection and advocacy systems authority and resources to expand P&A capacity to investigate incidents of abuse, seclusion, restraint and fatal incidents involving individuals with mental illness in public and private care and treatment facilities. In FY 2001, State P&A systems protections were also extended to individuals with significant mental illness or serious emotional disturbance residing in their own home and in the community.

Item: Rural, Native American Substance Abuse -- The Committee reiterates its concern about the disproportionate impact of substance abuse in rural and native communities, and has included $12,000,000 for native and rural CSAT programs. The Committee again raises concern about the severe shortage of substance abuse treatment services in the State of Alaska for Native Alaskans, the pressing need to continue support of Alaska programs, and the need to develop knowledge about effective techniques for treating substance abuse in native populations. The Committee, therefore, expects that the increase provided will be reasonably allocated between existing programs and initiating new programs, especially in Alaska. (Page 190)

Action Taken or to be Taken

In FY 2000, CSAT provided approximately $21.5 million in funds to increase knowledge about effective ways to deliver services to rural and native communities. It is expected that those programs will continue in FY 2001 and that additional efforts will be utilized to increase knowledge about effective ways to deliver services to rural and native communities. CSAT plans to support American Indian/Native Alaskan Planning Grants targeted toward those communities and tribes where the need for drug abuse treatment presently exists, but there is no treatment available in the affected communities. It is expected that $1 million will fund 8-10 planning grants.

Item: Services for the homeless -- The Committee remains concerned that substance abuse among the Nation's homeless population remains a serious problem that receives limited attention. Existing addiction services are not adequately reaching the homeless population and are not adequately addressing their unique needs and life circumstances. Of the funds provided for the Center for Substance Abuse Treatment Targeted Capacity Expansion program, the Committee recommends that the Department direct additional resources to entities that develop or expand addiction services specifically for homeless persons. The Committee expects the Department to distribute these funds to local public or nonprofit organizations through a competitive process. The Department should require applicants for the homeless funds to demonstrate integration with primary care and mental health services and linkages with housing, employment, and social services as a condition of the award. Establishment of a homeless TCE program should not restrict entities planning to serve

homeless persons from also competing for funding through the general TCE program. (Page 190-191)

Action Taken or to be Taken

In FY 2001, CSAT plans to use $10 million to support projects to help communities address drug and alcohol problems among homeless individuals by providing effective interventions. It is expected that 18-20 new awards will be made with these funds. This program is designed to enhance substance abuse treatment within a seamless system of services (i.e., primary health care, mental health, housing, and other social services) for homeless individuals with substance abuse disorders.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee is aware that Allegheny County, Pennsylvania is undertaking a treatment protocol known as the Supportive Recovery Environment (SRE) for underserved populations, including women with children known to the child welfare system, incarcerated inmates, adolescents for whom traditional treatment services have been ineffective, and individuals with co-occurring disorders. (Page 191)

Action Taken or to be Taken

CSAT plans to continue funding for this program in FY 2001, and award new funds in this area.

Item: Pregnant Women -- The Committee recognizes the success of the Fairbanks Native Association's residential treatment program in helping pregnant women with substance abuse problems, and their children. The Committee notes that additional funding for this important activity will allow more women to conquer their substance abuse problems. (Page 191)

Action Taken or to be Taken

CSAT plans to continue funding for the Fairbanks Native Association program, providing residential treatment for pregnant women with substance abuse problems, and their children. In addition, CSAT plans to award new funds for this program in FY 2001.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee understands that Mountain View in Huntington, Vermont is the only residential treatment center for adolescents in the State. (Page 191)

Action Taken or to be Taken

CSAT plans to award funds to the Vermont Department of Health in FY 2001 to establish a continuum of adolescent substance abuse treatment services.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee reiterates its support of the Southcentral Foundation in Anchorage and Norton Sound Health Corporation in Nome for providing substance abuse treatment programs for Native American adolescents. (Page 191)

Action Taken or to be Taken

CSAT plans to continue funding in FY 2001 for these programs, Southcentral Foundation in Anchorage and Norton Sound Health Corporation in Nome, which were originally awarded grants in FY 2000.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee continues to be supportive of the 5-point State of Alaska plan of action to prevent fetal alcohol syndrome and other birth defects and to improve the State's system of care for those individuals and their families already affected by prenatal exposure to alcohol. Alaska has one of the highest rates of Fetal Alcohol Syndrome in the nation. This demonstration program will provide Alaska with a clear understanding of the prevalence of FAS, data on the effects of the State's prevention efforts, and clear direction on how to improve prevention and treatment services. (Page 191)

Action Taken or to be Taken

CSAT plans to continue support for this program in FY 2001.

Item: Methamphetamine Use in the Midwest -- The Committee understands that methamphetamine abuse continues to be a major problem in many areas of the country, in particular, the South and the Midwest. The State of Iowa is experiencing a particularly high incidence of methamphetamine abuse. The Committee continues to support prevention and treatment demonstration projects in Iowa and other parts of the Midwest. School-based prevention demonstration projects would teach the dangers of methamphetamine abuse and addiction, using methods that are effective and evidence-based and include encouragement for students to create their own anti-drug abuse education programs for their schools. Treatment demonstrations would carry out planning, establishing, or administering evidence-based methamphetamine treatment programs that are designed to assist individuals to quit their use of methamphetamine and remain drug-free. (Pages 191-192)

Action Taken or to be Taken

In FY 1999, CSAT supported a Statewide methamphetamine treatment effort headed by the Single State Agency for Alcohol and Drug Abuse. This effort was funded as part of the Targeted Capacity Expansion Program. CSAT expects to continue this project in FY 2001 and encourages applications from the State of Iowa and other areas in the Midwest for funding under the FY 2001 Targeted Capacity Expansion grant announcement.

Item: Inhalant abuse -- The Committee continues to be concerned with the serious problem of inhalant abuse in Alaska, especially among children and teenagers. With approximately 1 in 4 Alaska children having used inhalants, it is clearly a critical and widespread problem. The Committee is aware that the Yukon-Kuskokwim Health Corporation is establishing a facility in Bethel, Alaska to treat individuals with inhalant addiction. (Page 192)

Action Taken or to be Taken

CSAT plans to make a grant continue funding for the Yukon-Kuskokwim Health Corporation Inhalant Intervention Project in FY 2001.

Item: Substance abuse treatment for the homeless -- The Committee is aware of the Hope Center in Lexington, Kentucky, which has a history of providing quality substance abuse treatment programs to homeless men. Hope Center is developing a similar program targeted at providing rehabilitation services for homeless women. The Committee recognizes that with funding from the Department, the Center will be able to provide services to more individuals. to provide funding for this program. (Page 192)

Action Taken or to be Taken

CSAT plans to make a grant award supporting this program in FY 2001.

Item: Fetal Alcohol Syndrome Regional consortium -- The Committee commends SAMHSA for funding the Fetal Alcohol Syndrome Regional Consortium in South Dakota, North Dakota, Minnesota, and Montana. The Committee supports continued funding for this important program that is helping children and families affected by alcohol-related birth defects. (Page 192)

Action Taken or to be Taken

SAMHSA/CSAP will continue supports funding the consortium project, which started in FY 2000. The objectives of the project are 1) to develop an information base for data collection on the prevalence of FAS and FAE and to determine high risk areas and populations in the four state area, and 2) to implement universal, selective and scientifically defensible prevention interventions to prevent, reduce or delay substance use to reduce FAS/FAE rates.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee applauds the work of the City of San Francisco's model "Treatment on Demand" program, which includes substance abuse and mental health services for homeless persons. The Committee applauds the work of Center Point, Inc., a private non-profit corporation that provides low cost comprehensive drug and alcohol services to high risk families and individuals in the San Francisco Bay area. (Page 192)

Action Taken or to be Taken

CSAT plans to continue funding for the City of San Francisco's model "Treatment on Demand" program in addition to providing new funds for this effort focusing on homeless populations in FY 2001. CSAT also plans to continue funding for the work of Center Point, Inc. as well as to provide new funds this fiscal year.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee is supportive of the Ai Ki Ruti center on the Winnebago Reservation in providing innovative substance abuse treatment services. (Page 192)

Action Taken or to be Taken

CSAT will provide information to this program on funding opportunities for FY 2001.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee is aware that the Pine Ridge Indian Reservation in the southwestern corner of South Dakota has a high incidence of alcohol addiction and that additional funds would allow the center to pursue innovative treatment alternatives. (Page 192)

Action Taken or to be Taken

CSAT will provide information to this program on funding opportunities for FY 2001.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee acknowledges the efforts of the Allegheny County Drug and Alcohol Rehabilitation Program in providing innovative drug and alcohol treatment services to patients in need. (Page 192)

Action Taken or to be Taken

CSAT plans to continue funding for this program in FY 2001. In addition, CSAT plans to award new funds for this program.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee understands that Baltimore is employing innovative techniques to enhance drug treatment services in the city. Additional funds would allow the city to increase the number of outpatients it can serve by providing more counselors, extending treatment center hours, and expanding program services. (Page 192)

Action Taken or to be Taken

CSAT plans to make a grant award for this program in FY 2001.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee applauds the work of Friendship House in Kansas City, Missouri for substance abuse and related service to high-risk women and children. Friendship House is establishing a model program to address what has become a severe and obvious need: treating the substance-abusing family with a specific focus on children. (Page 192)

Action Taken or to be Taken

CSAT will provide information to this program on funding opportunities for FY 2001.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee understands that the Cook Inlet Council on Alcohol and Drug Abuse is providing coordinated treatment services to meet the needs of an underserved group of women and their children who are in the custody of the State of Alaska and women affected by domestic violence in the Kenai Peninsula

area of Alaska and recognizes that funding from the Department would help more women and children become drug and alcohol free. (Pages 192-193)

Action Taken or to be Taken

CSAT will continue funding this program and will provide funds for a new program in FY 2001.

Item: Substance abuse treatment - KDA and targeted capacity expansion -- The Committee understands that the Navajo-Farmington Alcohol Crisis Response program is using innovative means to provide much-needed comprehensive substance abuse treatment services. (Page 193)

Action Taken or to be Taken

CSAT will provide information to this program on funding opportunities for FY 2001.

Item: High Risk Youth -- The Committee is highly concerned about the extent of substance abuse among high risk youth. This population is vulnerable to initiating criminal activity against people and property, especially following the acute and chronic use of illicit substances and the abuse of alcohol. These grants are intended to strengthen local capabilities in confronting the complex interrelationships between substance and alcohol abuse and other activities that may predispose young individuals toward criminal, self-destructive, or antisocial behavior. (Page 193)

Action Taken or to be Taken

In FY 2000, SAMHSA/CSAP supported a $7.0 million grant program focused on High Risk Youth. This program is designed to prevent or reduce substance abuse in youth (9 to 15 years old) by improving school bonding and academic performance, family functioning, and overall life management skills. CSAP will continue this program in FY 2001.

Item: SIG funding priorities -- The Committee expects that States receiving funding under the State Incentive Grant Program will give priority in the use of the 20 percent prevention set-aside in the block grant to: (1) working with community coalitions to develop community-wide strategic plans and needs assessments; and (2) filling program and service gaps identified by these community plans. (Page 194)

Action Taken or to be Taken

State Incentive Grants strongly encourage the use of the 20% prevention set-aside in the Block Grant to develop strategic plans and needs assessments and fill program and service gaps. SAMHSA/CSAP will incorporate this specific language into the revised State Incentive Grant Funding Application (GFA).

Item: Rural and Native communities -- The Committee reiterates its concern about the disproportionate impact of substance abuse in rural and native communities, and has included $8,000,000 for CSAP programs which serve rural communities. The Committee intends this increase

to be reasonably allocated between expanding existing programs and initiating new programs, especially in Alaska. (Page 194)

Action Taken or to be Taken

SAMHSA/CSAP has earmarked $8.0 million in funds to support substance abuse prevention efforts in rural and native communities. These funds support both new and continuing efforts in FY 2000, and will be further continued in FY 2001.

Item: Corporate Alliance for Drug Education prevention program --The Committee believes that prevention programs need to start when children are young, and need to continue to allow children to make successful transitions. The Committee has included sufficient funds for evaluations of established school-based early prevention and transition programs and continues to be supportive of the efforts of the Corporate Alliance for Drug Education [CADE] which has been operating a program providing education and prevention services to 120,000 elementary school-aged children in Philadelphia. (Page 194)

Action Taken or to be Taken

SAMHSA/CSAP plans to continue support to the Corporate Alliance for Drug Education (CADE) in Fiscal Year 2001.

Item: Alcoholism Prevention -- . . . the Committee urges CSAP to continue the national effort to provide alcohol and substance abuse prevention and education to children of Native Americans with alcoholism. (Page 194)

Action Taken or to be Taken

Through the Native American effort, SAMHSA/CSAP continues efforts to provide alcohol and substance abuse prevention and education to children of Native Americans with alcoholism. As part of this effort, SAMHSA/CSAP established a Native American Substance Abuse Prevention Work Group comprising such groups as the National Association of Native American Children of Alcoholics and the National Congress of American Indians. SAMHSA/CSAP maintains a strong commitment to the prevention needs of the Native American community through the existing grant portfolio and will be continuing this commitment in FY 2001.

Item: Drug Abuse Prevention - St Louis -- The Committee acknowledges the innovative Drug Free Families initiative at the University of Missouri-St. Louis in providing a comprehensive school-based health and drug abuse prevention program that involves parents and targets middle and high school students. (Page 194)

Action Taken or to be Taken

SAMHSA/CSAP will provide $500,000 in prevention funding for this program in FY 2001.

Item: Alcohol and substance abuse prevention -- The Committee encourages CSAP to continue support for alcohol and substance abuse prevention and education targeting Native American children of alcoholics through the National Association for Native American Children of Alcoholics headquartered in Washington State. The rates for alcohol-related deaths among American Indians is seven times the rate for the general population. Efforts to prevent the multigenerational effects of alcohol and substance abuse in Indian communities should continue.
(Page 194)

Action Taken or to be Taken

In FY 2000, the National Association for Native American Children of Alcoholics headquartered in Washington State suspended operations. As of January 2001, they have not re-established operations.

Significant Items for the House, Senate, and Conference Appropriations Committee Reports

FY 2001 Conference Report No. 106-1033

Item: Protection and advocacy -- The conference agreement includes $30,000,000 for protection and advocacy instead of $24,903,000 as proposed by the House and $25,903,000 as proposed by the Senate. The conferees continue to be concerned about deaths and serious injuries due to the inappropriate use of seclusion and restraints in facilities that treat individuals with mental illnesses and have provided additional resources so that these deaths can be investigated and future incidences can be prevented. (Page 144)

Action Taken or to be Taken

The FY 2001 budget and new legislative requirements from the Child Health Act of 2000, PL 106-310, for seclusion and restraint will provide State protection and advocacy systems authority and resources to expand P&A capacity to investigate incidents of abuse, seclusion, restraint and fatal incidents involving individuals with mental illness in public and private care and treatment facilities. In FY 2001, State P&A systems protections were also extended to individuals with significant mental illness or serious emotional disturbance residing in their own home and in the community.

Item: Safe Schools/Healthy Students initiative -- Within the total provided, $90,000,000 provided under section 581 of the Public Health Service Act is for the support and delivery of school-based and school-related mental health services for school-age youth. It is intended that the Department will continue to collaborate its efforts with the Department of Education to develop a coordinated approach. The conferees recognize it may be necessary for the agency to allocate additional resources to the Safe Schools/Healthy Students Action Center to expand its technical assistance to serve new grantees. (Page 144)

Action Taken or to be Taken

The Departments of Health and Human Services, Justice, and Education will continue their interagency partnership and will continue to fund the empirically-supported programs to prevent youth violence and to intervene with families, schools, and communities where violence has already occurred. This interagency team is currently working on a new grant announcement for FY 2001.

CMHS is reviewing the resources available to the Safe Schools/Healthy Students Action Center to assure that they are sufficient to provide technical assistance to serve new grantees.

Item: Suicide Prevention Hotlines --Within the total provided, $3,000,000 is for suicide prevention hotlines. The conferees direct SAMHSA to undertake an evaluation of the effectiveness of these hotlines in preventing suicides. (Page 144)

Action Taken or to be Taken

SAMHSA will initiate a new program in FY 2001 to increase the number of certified programs and to evaluate the effectiveness of suicide hotlines in the amount of $3 million.

Item: Suicide prevention clearinghouse -- The conferees believe that SAMHSA is uniquely qualified to support a clearinghouse for youth suicide prevention, including a database and related files of reference materials and organizations. SAMHSA, through this clearinghouse, could provide training and technical assistance to States to implement the Surgeon General's recommendations for suicide prevention. (Page 144)

Action Taken or to be Taken

Through the CMHS clearinghouse, the Knowledge Exchange Network (KEN), a website will be launched on the National Suicide Prevention Strategy.

Item: Grants to mental health providers for children and youth -- Within the total provided, $10,000,000 is provided under section 582 of the Public Health Service Act to support up to 22 grants to local mental health providers for the purposes of developing knowledge of best practices and providing mental health services to children and youth suffering from post traumatic stress disorder as a result of having witnessed or experienced a traumatic event. Grantees can include psychiatric hospitals, general hospitals, outpatient mental health clinics, and community and university-based mental health programs. With respect to grants for knowledge development, preference should be given to applicants with experience in the field of trauma related mental disorders in children and youth. (Pages 144-145)

Action Taken or to be Taken

In FY 2001, SAMHSA will begin the National Child Traumatic Stress Program (NCTSP). This program will further the understanding of the individual, familial, and community impact of child and adolescent trauma; improve the quality, effectiveness, and availability of therapeutic services delivered to traumatized children and adolescents; and reduce the frequency of traumatic events and their long-term consequences through greater public recognition of the issue, deeper understanding of the sequelae, and improved services.

Item: Training in restraints and seclusion -- Within the total provided, $2,000,000 is to support professional training in restraints and seclusion in residential and day treatment centers for children and youth. This training initiative will support grants to non-profit and public entities for the purpose of developing and demonstrating the effectiveness of a best-practices training model to avoid the inappropriate use of restraints and seclusion. (Page 145)

Action Taken or to be Taken

In FY 2001, CMHS will award cooperative agreements in the amount of $2,000,000 to support training in restraints and seclusion.

Item: Training demonstration -- The conferees are supportive of efforts to develop a model training demonstration project to help eliminate deaths and injuries that occur in mental health facilities due to the inappropriate use of seclusion and restraints. Such a model training program should emphasize conflict resolution and de-escalation. (Page 145)

Action Taken or to be Taken

In FY 2001, CMHS will award cooperative agreements in the amount of $2,000,000 to support training in restraints and seclusion.

Item: Minority fellowships -- Within the total provided, an increase of $2,000,000 is to provide additional support for minority fellowships in mental health. (Page 145)

Action Taken or to be Taken

In FY 2001, SAMHSA will provide an increase of $2 million for the Minority Fellowship Program.

Item: Treatment of mental health disorders related to HIV disease -- Within the total provided, $7,000,000 is for the treatment of mental health disorders related to HIV disease including: dementia, clinical depression and the chronic, progressive neurological disabilities that often accompany HIV disease. These direct services grants provided to minority community-based providers that operate in traditional and non-traditional settings are designed to strengthen their capacity to provide HIV related mental health services. (Page 145)

Action Taken or to be Taken

In FY 2001, SAMHSA will initiate a new service delivery program in the amount of $7 million for the treatment of mental health disorders related to HIV disease.

Item: Mental health screening -- Funds are included to provide grants to local communities to improve mental health screening and referrals in non-mental health settings and continue support for jail diversion programs for non-violent mentally ill offenders. (Page 145)

Action Taken or to be Taken

In FY 2001, CMHS will award grants to meet emerging and urgent mental health services needs of communities and is continuing support for jail diversion programs.

Item: Mental Health program funding -- The conferees include the following amounts for the following projects and activities in fiscal year 2001: --$83,000 for the Hope Center in Lexington, Kentucky; --$85,000 for Steinway Child and Family Services, Inc. in Queens, New York for HIV/AIDS prevention; --$100,000 for the American Trauma Society to support its Second Trauma Program which helps train trauma system health care professionals to assist individuals facing the shock of an unexpected death or critical injury to their family members; --$200,000 for the Concord-Assabet Family Services Center for a model transitional living program for troubled youth; --$325,000 for Preschool Anger Management, Family Communications; --$500,000 for the Life

Quest Community Mental Health Center in Wasilla, Alaska; --$680,000 for Pacific Clinics in Arcadia, California, to support a school-based mental health demonstration program for Latina adolescents in partnership with community groups, mental health agencies, local governments and school systems in Southeast Los Angeles county; --$803,000 for the Bert Nash Community Mental Health Center in Lawrence, Kansas, to provide mental health services in schools and other settings to prevent juvenile crime and substance abuse among high-risk youth; –$800,000 for the Alaska Federation of Natives for innovative homeless mental health services in Alaska; --$850,000 for the Iowa State University Extension to develop a program which would provide outreach, training, and counseling services in rural areas; --$921,000 for the United Power for Action and Justice demonstration project in Chicagoland area to end the cycle of homelessness; --$921,000 for a mentally ill offender crime reduction demonstration in Ventura County, California to create the building blocks for a continuum of care for mentally ill offenders who enter the jail system in the county; --$850,000 for the University of Connecticut for an urban health initiative to improve mental health services to underserved high-risk individuals living in urban public housing; --$1,007,000 for the University of Florida National Rural Behavioral Health Center to train extension agents in crisis intervention and stress management to better equip them to deal with emotional and stress related problems; --$1,500,000 for the Ch'eghutsen program in interior Alaska; and --$1,300,000 for the Alaska Federation of Natives to use integrated community care to treat native Alaska children with mental health disorders. (Pages 144-145)

Action Taken or to be Taken

SAMHSA has developed a streamlined application process for all of these projects. Earlier this year, CMHS contacted and mailed applications to the organizations cited in this conference language. We expect to award funds in the identified amounts to these organizations by the end of the fiscal year.

Item: Programs of regional and national significance/substance abuse services for the homeless -- The conference agreement includes $256,315,000 for programs of regional and national significance instead of $213,716,000 as proposed by the House and $249,566,000 as proposed by the Senate. Within the total provided, $10,000,000 is to initiate grants to local non-profit and public entities for the purpose of developing and expanding substance abuse services for homeless persons. (Page 146)

Action Taken or to be Taken

In FY 2001, CSAT plans to use $10 million to fund projects to help communities address drug and alcohol problems among homeless individuals by providing effective interventions. It is expected that 18-20 new awards will be made with these funds. This program is designed to enhance substance abuse treatment within a seamless system of services (i.e., primary health care, mental health, housing, and other social services) for homeless individuals with substance abuse disorders.

Item: Expansion and capacity building for substance abuse treatment and HIV/AIDS -- The agreement includes $53,000,000 designed to provide targeted service expansion and capacity building to minority, community-based substance abuse treatment programs with a history of providing services to communities of color severely impacted by substance abuse and HIV/AIDS. The correlation between addiction and HIV/AIDS is well documented. Injection drug use alone still

accounts for more than 20 percent of the primary HIV infection risk for African American and Latino adults. These funds are to be allocated based on program priorities identified in the previous fiscal year and new priorities. Funds are also included to enhance state and county efforts to plan and develop integrated substance abuse and HIV/AIDS treatment and prevention services to communities of color. (Page 146)

Action Taken or to be Taken

CSAT plans to continue funding for the Targeted Capacity Expansion HIV program in FY 2001 which targets African American and Latino populations impacted by substance abuse and HIV/AIDS. The total amount of funds planned for this program in FY 2001, for continuation and new awards as well as some technical assistance and evaluation activities, is approximately $55 million.

Item: Sunshine Shelter in Mississippi -- The conferees are supportive of the efforts of the Sunshine Shelter for abused and neglected children in Natchez, Mississippi in treating chemically dependent women and their children and note that additional resources would allow the Shelter to expand its outreach efforts. (Page 147)

Action Taken or to be Taken

CSAT will provide information to this program on funding opportunities for FY 2001.

Item: Treatment program funding -- The conferees include the following amounts for the following projects and activities in fiscal year 2001: --$100,000 for the Vermont Department of Health Office of Alcohol and Drug Abuse Prevention to examine adolescent residential treatment programs; --$106,000 for Center Point, Inc., in Marin County, California, to continue support for substance abuse and related services for minority, homeless and other at risk populations; --$200,000 for Green Door in Washington, D.C. to treat minority consumers with substance abuse problems and mental health issues; --$250,000 for the Allegheny County Drug and Alcohol Rehabilitation Program; --$500,000 for the Cook Inlet Council on Alcohol and Drug Abuse Treatment; --$500,000 for the House of Mercy in Des Moines, Iowa to support treatment programs for pregnant and post-partum women; --$500,000 for the State of Wyoming to carry out an innovative substance abuse prevention and treatment program; --$425,000 for Humboldt County, California, to support residential substance abuse and related services for women who have children; --$608,000 for the Hope Center in Lexington, Kentucky; --$645,000 for the Grove Counseling Center in Winter Springs, Florida for a demonstration project of effective youth substance abuse treatment methods; --$750,000 for the Fairbanks LifeGivers Pregnant and Parenting Teens program; --$900,000 for the Alaska Federation of Natives to identify best substance abuse treatment practices; --$1,105,000 for the City of San Francisco's model "Treatment on Demand" program for the homeless; and --$2,210,000 for the Baltimore City Health Department to use innovative methods to enhance drug treatment services. (Page 147)

Action Taken or to be Taken

SAMHSA has developed a streamlined application process for all the identified projects. In mid-February 2001, CSAT contacted and mailed applications to the organizations cited in this conference language. We expect to award these funds to these organizations by the end of the fiscal year.

Item: High risk youth grants -- The conference agreement includes $175,145,000 for programs of regional and national significance instead of $132,742,000 as proposed by the House and $127,824,000 as proposed by the Senate. Within the total provided, it is intended that high-risk youth grants will at least be maintained at last year's level. (Page 147)

Action Taken or to be Taken

In FY 2000, SAMHSA/CSAP supported a $7.0 million grant program focused on High Risk Youth. This program is designed to prevent or reduce substance abuse in youth (9 to 15 years old) by improving school bonding and academic performance, family functioning, and overall life management skills. CSAP will continue this program at the same level in FY 2001.

Item: Grants to minority organizations for HIV/AIDS prevention -- The agreement includes $32,100,000 for grants to minority community based organizations to implement programs that strengthen substance abuse prevention capacity in communities of color disproportionately impacted by the HIV/AIDS epidemic, based on the most recent estimated living AIDS cases, HIV infections and AIDS mortality among ethnic and racial minorities as reported by the CDC. (Page 147-148)

Action Taken or to be Taken

CSAP will support $32,100,000 to support minority communities in their efforts to integrate effective substance abuse prevention programs with HIV/AIDS prevention and care services. This program builds upon our earlier efforts to support minority communities in their efforts to address both substance abuse and HIV/AIDS.

Item: Prevention program funding -- The conferees include the following amounts for the following projects and activities in fiscal year 2001: --$85,000 for the City of Alexandria, Virginia, substance abuse prevention demonstration program for high-risk Latino youth; --$213,000 for the Rock Island County Council on Addiction in East Moline, Illinois, for a youth substance abuse prevention program; and --$500,000 for the Drug-free Families Initiative at the University of Missouri, St. Louis. (Page 148)

Action Taken or to be Taken

SAMHSA has developed a streamlined application process for all the identified projects. In mid-February 2001, CSAP contacted and mailed applications to the three organizations cited in this conference language. Funds will be awarded o these organizations by the end of the fiscal year.

Item: Substance abuse prevention -- The conferees have included sufficient funds to continue the pregnant and post-partum substance abuse prevention evaluations for both the Community Prevention Partnership of Berks County, Inc. and the Family Planning Council of Pennsylvania. (Page 148)

Action Taken or to be Taken

CSAP will continue to fully support the prevention evaluations for both the Community Prevention Partnership of Berks County, Inc. and the Family Planing Council of Pennsylvania.

Item: National Household Drug Survey -- The conference agreement includes $79,221,000 for program management instead of $58,870,000 as proposed by the House and $59,943,000 as proposed by the Senate. Within the total provided, $12,000,000 is for the National Household Drug Survey. (Page 148)

Action Taken or to be Taken

The $12 million included in Program Management will be used to support the National Household Drug Survey.

Item: Community Assessment and Intervention Centers -- The conferees include $3,278,000 in fiscal year 2001 to continue testing the effectiveness of Community Assessment and Intervention Centers in providing integrated mental health and substance abuse services to troubled and at-risk children and youth, and their families in four Florida communities. (Page 148)

Action Taken or to be Taken

In FY 2001, SAMHSA will continue to fund the Community Assessment and Intervention Centers in the amount of $3,278,000. During the first six months of this project, the four target communities have: Conducted outreach to local stakeholders; collected regional information on youth characteristics and existing resources; and selected sites for the assessment centers. Currently, project personnel are researching: (1) screening and assessment tools; (2) potential Management Information Systems; and (3) models of systems' evaluation reporting.

Item: Synar amendment -- The Synar amendment was included as part of the SAMHSA reorganization bill in 1992. The amendment and its implementing regulation required States to reduce sales of tobacco to minors within a negotiated period of time and if a State fails to meet its goals, reduced its substance abuse prevention and treatment block grant funding by 40 percent. The conferees are extremely concerned that several States, after at least four years, are not in compliance with the law and continue to seek an exemption to the penalty requirement. It is the conferees intention that this will be the last year exemption language will be carried in an appropriations bill. SAMHSA is directed to notify States of this intention and work with the affected States to help them come into compliance. (Page 148)

Action Taken or to be Taken

The budget proposes to retain the provision allowing states to avoid the penalty in the Synar Amendment if they commit to spending their own funds on youth tobacco compliance and enforcement. The Administration looks forward to working with Congress to formulate a permanent statutory change to the Synar penalty structure that ties the amount of the penalty to the degree of non-compliance. In addition, CSAP continues to work with the affected States by providing technical assistance and training to reduce youth tobacco sales and to bring the States into compliance with the law.

Substance Abuse and Mental Health Services Administration
Authorizing Legislation

Program Description/PHSA	FY 2001 Amount Authorized	FY 2001 Current Estimate	FY 2002 Amount Authorized	FY 2002 Budget Request
Program Management Sec. 301	indefinite	$65,673,000	indefinite	$65,673,000
Grants and Contracts Sec. 501	$25,000,000	$17,528,000	SSAN*	$8,244,000
Emergency Response Sec. 501	2.5% all disc grants	**	2.5% all disc grants	**
Data Collection Sec. 505	indefinite	$12,000,000	indefinite	**
Grants for the Benefit of Homeless Individuals Sec. 506	$50,000,000	**	SSAN	**
Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans Sec. 506A	$15,000,000	**	SSAN	**
Grants for Ecstasy and Other Club Drugs Abuse Prevention Sec. 506B	$10,000,000	**	SSAN	**
Residential Treatment Programs for Pregnant and Postpartum Women Sec. 508	SSAN	**	SSAN	**
Priority Substance Abuse Treatment Needs of Regional and National Significance Sec. 509	$300,000,000	$247,322,000	SSAN	$287,322,000
SA Treatment Services for Children and Adolescents Sec. 514	$40,000,000	$2,500,000	SSAN	$2,500,000
Early Intervention Services for Children and Adolescents Sec. 514A	$20,000,000	**	SSAN	**
Methamphetamine and Amphetamine Treatment Initiative Sec. 514(d)	$10,000,000	**	SSAN	**
Priority Substance Abuse Prevention Needs of Regional and National Significance Sec. 516	$300,000,000	$155,513,000	SSAN	$156,813,000
Prevention, Treatment, and Rehabilitation Model Projects for High Risk Youth Sec. 517	SSAN	$7,000,000	SSAN	$7,000,000
Services for Children of Substance Abusers Sec. 519	$50,000,000	**	SSAN	**

Substance Abuse and Mental Health Services Administration
Authorizing Legislation

Program Description/PHSA	FY 2001 Amount Authorized	FY 2001 Current Estimate	FY 2002 Amount Authorized	FY 2002 Budget Request
Grants for Strengthening Families Sec. 519A	$3,000,000	$1,300,000	SSAN	**
Programs to Reduce Underage Drinking Sec. 519B	$25,000,000	**		
Services for Individuals with Fetal Alcohol Syndrome Sec. 519C	$25,000,000	$11,500,000	SSAN	$11,500,000
Centers of Excellence on Services for Individuals with FAS and Alcohol-related Birth Defects and Treatment for Individuals with Such Conditions and Their Families Sec. 519D	$5,000,000	$3,500,000	SSAN	$3,500,000
Prevention of Methamphetamine and Inhalant Abuse and Addiction Sec. 519E	$10,000,000	**	SSAN	**
Priority Mental Health Needs of Regional and National Significance Sec. 520A	$300,000,000	$100,884,000	SSAN	$80,749,000
Youth Interagency Research, Training, and Technical Assistance Centers Sec. 520C	$4,000,000	**	SSAN	**
Services for Youth Offenders Sec. 520D	$40,000,000	**	SSAN	**
Suicide Prevention for Children and Adolescents Sec. 520E	$75,000,000	**	SSAN	**
Grants for Emergency Mental Health Centers Sec. 520F	$25,000,000	**	SSAN	**
Grants for Jail Diversion Programs Sec. 520G	$10,000,000	**	SSAN	**
Improving Outcomes for Children and Adolescents through Services Integration between Child Welfare and MH Services Sec. 520H	$10,000,000	**	SSAN	**
Grants for the Integrated Treatment of Serious Mental Illness and Co-occurring Substance Abuse Sec. 520I	$40,000,000	**	SSAN	**
Training Grants Sec. 520J	$25,000,000	**	SSAN	**
PATH Grants to States Sec. 535(a)	$75,000,000	$36,855,000	$75,000,000	$36,855,000

Substance Abuse and Mental Health Services Administration
Authorizing Legislation

Program Description/PHSA	FY 2001 Amount Authorized	FY 2001 Current Estimate	FY 2002 Amount Authorized	FY 2002 Budget Request
Community Mental Health Services for Children with Serious Emotional Disturbances Sec. 561	$100,000,000	$91,694,000	SSAN	$91,694,000
Children and Violence Program Sec. 581	$100,000,000	$70,822,000	SSAN	$85,106,000
Grants for Persons who Experience Violence Related Stress Sec. 582	$50,000,000	$10,000,000	SSAN	$10,000,000
Community Mental Health Services Block Grants Sec. 1920(a)	$450,000,000	$420,000,000	SSAN	$420,000,000
Substance Abuse Prevention and Treatment Block Grants Sec. 1935(a)	$2,000,000,000	$1,665,000,000	SSAN	$1,725,000,000
Data Infrastructure Development Sec. 1971	SSAN	$6,765,000	SSAN	$6,000,000
Other Legislation/Program Description				
Protection and Advocacy for Mentally Ill Individuals P.L. 99-319, Sec. 117	SSAN	$30,000,000	SSAN	$30,000,000
SEH Workers' Compensation Fund P.L. 98-621	indefinite	$1,500,000	indefinite	$1,500,000
TOTAL against definite authorizations	$4,192,000,000	$2,957,356,000	$75,000,000	$36,855,000
Total Requested		$2,957,356,000		$3,029,456,000

* Such Sums As Necessary

** While funding is not specifically requested for this authorized activity, these activities may be supported with the funding requested for PRNS or the Block Grants.

Substance Abuse and Mental Health Services Administration
Appropriations History

	Budget Estimate to Congress		House Allowance		Senate Allowance		Appropriation	
Alcohol, Drug Abuse, and Mental Health Administration								
1990	1,738,716,000		1,917,162,000		2,005,448,000		1,926,818,000	1/
1990 Sec 518 Red.	---		---		---		-1,135,000	
1990 (DOT Appr)	300,000,000		---		---		727,000,000	
1990 Sequester	---		---		---		-26,745,000	
1991	2,831,511,000	2/	2,825,891,000	1/3	3,000,283,000	1/	2,966,898,000	1/
1991 Sec 514 Red.	---		---		---		-77,039,000	
1991 Sequester	---		---		---		-38,000	
1992	3,048,328,000	4/	2,917,742,000	4/	3,175,832,000		3,081,119,000	5/
1992 Sec 513, Sec 214 Red.	---		---		---		-8,389,000	
1993	3,241,159,000	6/	3,099,902,000	6/	n.a.		n.a.	
Substance Abuse and Mental Health Services Administration								
1993 7/	2,037,928,000	6/	1,942,417,000	6/	2,049,609,000	6/	2,023,524,000	8/
1993 Sec 216, 511, 513 Red.	---		---		---		-18,721,000	
1994	2,153,480,000	9/	2,057,167,000		2,119,205,000	10/	2,125,178,000	11/
1995	2,365,874,000	12/	2,166,148,000		2,164,179,000	13/	2,181,407,000	14/
1995 Red. P.L.103-333	---		---		---		-33,000	
1995 Red. P.L. 103-133	---		---		---		-44,000	
1995 Resc. P.L. 104-19	---		---		---		-662,000	
1996	2,244,392,000		1,788,946,000		1,800,469,000	15/	1,854,437,000	16/
1997	2,098,011,000		1,849,946,000		1,873,943,000		2,134,743,000	
1997 Red. P.L. 104-208	---		---		---		-362,001	
1997 Red. P.L. 104-208	---		---		---		-69,000	
1997 Advance Appro. P.L.104-121			---		---		+50,000,000	17/
1998	$2,155,943,000		$2,151,943,000		$2,126,643,000		$2,146,743,000	
1998 Advance Appro. P.L. 104-121			---		---		+50,000,000	17/
1999	2,279,643,000		2,458,005,000		2,151,643,000		2,488,005,000	

Substance Abuse and Mental Health Services Administration
Appropriations History (Continued)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2000	2,626,505,000	2,413,731,000	2,750,700,000	2,654,953,000
2000P.L.106-113				-3,085,000 18/
2001	2,823,016,000	2,727,626,000	2,730,757,000	2,958,001,000
2001P.L.106-554				-645,000 19/
2002	3,029,456,000	—	—	—

FOOTNOTES:

1/ Excludes advance funding for Homeless.
2/ Includes $7,359,000 in 1991 Advance Funding for Homeless.
3/ House did not consider research training Community Support program; and mental health prevention demonstrations program as it lacked authorizing legislation.
4/ Excludes $31,000,000 proposed to be transferred from the Office of National Drug Control Policy (ONDCP) Special Forfeiture Fund.
5/ Excludes $19,000,000 transferred from the Special Forfeiture Fund.
6/ Excludes $34,701,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
7/ FY 1993 Budget Estimate to Congress and House Allowance represent comparable funding levels based on the 1992 ADAMHA Reorganization Act as identified in Conference Report.
8/ Excludes $33,701,000 transferred from the ONDCP Special Forfeiture Fund.
9/ Includes $115,000,000 Presidential Investment.
10/ Excludes $35,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
11/ Excludes $25,000,000 transferred from the ONDCP Special Forfeiture Fund.
12/ Excludes $45,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
13/ Excludes $25,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
14/ Excludes $14,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund. Reflects $44,000 in SLUC and $33,000 in performance awards reductions mandated by the appropriation bill and a rescission in the amount of $662,000.
15/ Includes $200,000,000 proposed transfer from the Safe and Drug Free Schools Act program of the Dept of Education for youth substance abuse prevention programs in schools and communities.
16/ A regular 1996 appropriation for this amount was not enacted.
17/ Advance appropriation P.L. 104-121 from Social Security Administration to Substance Abuse Block Grant.
18/ Reflects a recission mandated by P.L.106-113.
19/ Reflects a recission mandated by Section 520 of P.L. 106-554.

Note: Red = Reduction

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
General Statement/Overview

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase/ Decrease
PRNS	$497,828,000	$635,134,000	$634,634,000	+$136,806,000	$658,734,000	+$24,100,000
MH (Non-add)	*(136,733,000)*	*(203,674,000)*	*(203,499,000)*	*(+66,766,000)*	*(187,599,000)*	*(-15,900,000)*
SAP (Non-add)	*(146,705,000)*	*(175,145,000)*	*(175,013,000)*	*(+28,308,000)*	*(175,013,000)*	*(---)*
SAT (Non-add)	*(214,390,000)*	*(256,315,000)*	*(256,122,000)*	*(+41,732,000)*	*(296,122,000)*	*(+40,000,000)*
Child MH	82,677,000	91,763,000	91,694,000	+9,017,000	91,694,000	---
P & A	24,903,000	30,000,000	30,000,000	+5,097,000	30,000,000	---
PATH	30,883,000	36,883,000	36,855,000	+5,972,000	36,855,000	---
MHBG	356,000,000	420,000,000	420,000,000	+64,000,000	420,000,000	---
SAPTBG	1,600,000,000	1,665,000,000	1,665,000,000	+65,000,000	1,725,000,000	+60,000,000
PM	59,049,000	79,221,000	79,173,000	+20,124,000	67,173,000	-12,000,000
Total BA	$2,651,340,000	$2,958,001,000	$2,957,356,000	+$306,016,000	$3,029,456,000	+$72,100,000
Data Collect (1% Eval)	---	---	---	---	$29,000,000	+$29,000,000
Total	2,651,340,000	$2,958,001,000	$2,957,356,000	+$306,016,000	$3,058,456,000	+$101,100,000
FTEs*	541	560	560	560	—	

* Excludes 72 Commissioned Officers (70 in FY 2000) detailed to the District of Columbia for St. Elizabeth's Hospital.

The President's appropriation request of $3,058,456,000 for this account represents current law requirements. No proposed law amounts are included.

AGENCY OVERVIEW

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency for improving the quality and availability of prevention and treatment services for substance abuse and mental illness. The Agency was established in 1992 and reauthorized in October of 2000. SAMHSA is charged with conducting categorical, formula, and block grant programs, and data collection activities through the Center for Mental Health Services (CMHS); the Center for Substance Abuse Prevention (CSAP); the Center for Substance Abuse Treatment (CSAT); and the Office of Applied Studies (OAS).

The FY 2002 SAMHSA budget request is $3,029,456,000, an increase of $72.1 million or 2.4 percent over FY 2001. In addition to the requested increase in budget authority, $29.0 million is requested for SAMHSA data efforts to be transferred to the Agency from the Department's one-percent evaluation resources. In total, SAMHSA programs would increase by $101.1 million. Staffing resources would remain level at approximately 560 full-time equivalents (FTEs).

As displayed in the table above, the priorities for FY 2002 include:

- **The President's Drug Treatment Initiative.** An additional $100 million is provided to increase access to drug treatment services and work to narrow the treatment gap. Of this

amount, $60 million is requested for the Substance Abuse Prevention and Treatment Block Grant, and $40 million is requested for Targeted Capacity Expansion (TCE) within Programs of Regional and National Significance (PRNS).

- Implementing new program authorities identified in the Children's Health Act of 2000, which reauthorized SAMHSA programs. These include such important new efforts as post-traumatic stress disorders (PTSD) in children; fetal alcohol syndrome/fetal alcohol effect (FAS/FAE); suicide prevention; training in appropriate seclusion and restraint practices; improving and expanding treatment services for homeless individuals; and supporting State data infrastructure development.

- Maintaining a balanced program portfolio to improve service quality, transfer knowledge into practice, and continue progress in addressing service capacity needs where they exist.

- Initiating limited but essential new work within "base" funding in such areas as disaster consequences; providing mental health services through Community and Migrant Health Centers; creating a pilot rehabilitation and restitution program for substance abusing offenders; and initiating State data infrastructure development for substance abuse treatment.

- Expanding national substance use data collection and analysis in the areas of youth, the elderly, cost data on treatment services, and treatment programs in correctional facilities, in addition to upgrading existing data systems.

- Maintaining essential staff and management capability within the Agency.

These priorities are described briefly in the following narrative within the context of three themes which build upon and amplify SAMHSA's mission: developing and translating research and best practices into broad use by service providers; building healthy communities; and closing major service gaps which exist in both the mental health and substance abuse systems. Each theme is comprised of multiple programs which work together to improve system quality while simultaneously expanding capacity.

IDENTIFICATION OF PRIORITY SYSTEM NEEDS

SAMHSA's FY 2002 themes address serious issues currently facing the service fields, as identified in several recent studies and reports. With respect to the need to ensure best practices are actually employed in service delivery, on March 1, 2001, the Institute of Medicine released a report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century." The Committee on the Quality of Health Care found strong evidence that Americans are not receiving care that meets their needs or that is based on the best scientific knowledge. The report points out that while substantial new investments have been made in research, the Nation's health care system falls short in its ability to translate knowledge into practice. SAMHSA believes that prevention and treatment service approaches must be evidence-based and there must be real accountability for recipients. The FY 2002 request will help assure that biomedical and health services research findings are translated into best practices and that individuals have access to the best possible quality of care available.

> Heroin addiction has reached epidemic levels in Baltimore with as many as one in 10 of the city's residents addicted to the drug. The number of addicts will continue to rise according to a Drug Enforcement Agency report released in February.

A number of recent reports have documented the impact of mental illness and substance abuse on the Nation's communities. The Surgeon General's Report on Mental Health indicated that members of diverse racial/ethnic groups are less likely to receive appropriate mental health care than the general population. Recent news reports indicate that as many as one in ten of the residents of Baltimore are addicted to heroin, approaching epidemic levels. The enormous economic cost of these diseases is reflected in the losses caused by premature death and disability, and the high cost of crime, destruction of property, HIV/AIDS and other associated diseases, and the impact on other family members. These and related issues are addressed in the FY 2002 request through such proposed efforts as HIV/AIDS service projects in minority communities; providing treatment and other services for those re-entering the community after incarceration; community and family programs, and working with the Health Resources and Services Administration to provide services and referrals to those with mental illness or substance abuse who seek health care at Community and Migrant Health Centers.

Underage drinking remains a critical public health challenge, with data from the National Household Survey on Drug Abuse reporting that more than half of adolescents ages 16 and 17 used alcohol in the past year. Alcohol is the number one drug of choice among this country's youth. Current alcohol-related priorities for SAMHSA are preventing/reducing underage drinking and increasing access to treatment for persons of any age with alcohol use disorders. Key cross-cutting alcohol activities in support of these priorities are increasing participation of community sites and college students in National Alcohol Screening Day; developing an alcohol measure for Healthy People 2010 to track progress in increasing access to needed treatment; and working with single State substance abuse agencies and through State Incentive Grants to support the Governor's Spouses Initiative: Leadership to Keep Children Alcohol Free, a national effort to prevent alcohol use by children ages 9 to 15.

Beyond assisting communities in meeting their targeted needs, the SAMHSA request will help address the general lack of behavioral health service capacity. This service gap is also well documented. It is, however, a complex problem with multiple facets. Gaps can be geographic, population-based, or relate to health insurance or managed care coverage. There are major gaps in speciality health systems, such as those involving children and their families. Care which is available may be fragmented or compartmentalized, providing short-term relief but leading to eventual relapse.

A recent study by the National Center on Addiction and Substance Abuse (CASA) at Columbia University, "*Shoveling Up: The Impact of Substance Abuse on State Budgets*," found that of the annual $81.3 billion spent by States on substance abuse in 1998, only $3.2 billion (4%) was spent for treatment, prevention and research. Fully $78.1 billion (96%) was spent on justice, education, child/family assistance, developmental disabilities, etc. CASA estimates that $1 of every $4 inpatient hospital care Medicare dollars, and one out of every five Medicare hospital admissions, are attributable to substance abuse. According to the recently released Robert Wood Johnson Foundation report "Substance Abuse: The Nation's Number One Health Problem," the economic cost of substance abuse to the U.S. economy each year is estimated at over $414 billion. Expansion of

SAMHSA's prevention and treatment programs are a key element of the Administration's plan of action to address these needs.

IMPLEMENTING BEST PRACTICES

A continuing key role of SAMHSA is to facilitate the translation of the latest research to public health and private practice. Research findings for substance abuse and mental health are implemented and evaluated for effectiveness and efficiency in various communities and other real life settings to determine what works best for different populations. SAMHSA then disseminates proven program models to help communities invest scarce resources wisely and to improve program outcomes. The FY 2002 request continues most activities at the current level.

SAMHSA's knowledge development and knowledge application programs form the foundation for the Agency's service programs. Best practices which have been carefully evaluated through project-based and cross-site studies are made available through multiple communication channels. These include efforts such as CSAP's Decision Support System, CMHS' Knowledge Exchange Network, and the National Registry of Effective Prevention Practices (NREPP). They are made available to the field in readily understandable and readily accessible formats. And they are being incorporated as core requirements of service programs where possible, such as State Incentive Grants awarded in CSAP and proposed for 2002 in CSAT.

SAMHSA has in fact accomplished a great deal in a relatively short time, improving service quality and the Agency's role in the service delivery system. Yet much remains to be done; as reported above, quality care is far from universally available. The FY 2002 request includes a number of important efforts proposed to be accomplished within level funding, with grant funds that will become available as other projects complete their award cycles. These efforts are identified as "FY 2002 Priority Investments" in the budget narrative. Examples include:

- Facilitating transitions for youth with mental illnesses - Transitions between service systems for youth present unique barriers that create great risk for school failure, homelessness, involvement with the criminal justice system, etc. The transition period is complicated by the lack of coordination among children's mental health and other services. CMHS will explore how best to plan, design, and put into practice effective transitional services.

> "...over 90 percent of children and adolescents who commit suicide have a mental disorder before their death."
> - Surgeon General's Report on Mental Health

- Applying best prevention practices - CSAP's Community Initiated Intervention projects select and adapt proven prevention interventions that meet the specific prevention needs of the local target population. Cross-site evaluations yield data on what works for different populations and under which range of circumstances. This information is then used by CSAP to assist other communities in employing optimal prevention approaches.

- Supporting rehabilitation and restitution for substance abusing offenders - CSAT will begin to develop and evaluate a program to assist non-violent substance abusing offenders to recover from

their addiction, provide restitution to victims and the community, and become more fully functioning citizens. Understanding what constitutes best practice and how systems can be changed accordingly will lead to better retention in treatment and improved outcomes.

CREATING HEALTHY COMMUNITIES

SAMHSA possesses significant expertise in helping communities, including faith-based organizations, design and create programs that address their particular needs without requiring the long-term investment of SAMHSA resources. The President's New Freedom Initiative recognizes that providing community-based care for persons with disabilities is critical for promoting maximum independence. This is consistent with SAMHSA efforts to address barriers that face many Americans with disabilities and to support fully integrated community-based service settings. In addition to continuing several important programs in FY 2002, the Agency will partner with the Administration for Children and Families (ACF) in promoting responsible fatherhood, helping families in crisis so that children are protected from abuse and neglect, and helping promote safe and stable families which will keep children out of foster care.

All of SAMHSA's community-based efforts will continue in FY 2002. These projects help communities in a variety of ways: establishing service capacity, developing system linkages and referral programs, providing ancillary services, such as screening, case management and aftercare, and others. An important example is the youth violence prevention program, which has a major focus on school-based efforts. Working through several different but related activities, CMHS will continue to work with the Departments of Justice and Education in addressing this significant national concern. A total of $90.0 million has been budgeted, the same as in FY 2001.

Services for the homeless will be expanded in FY 2002 by assisting communities to link systems of primary care, mental health, housing and other social services. Approximately 25 to 40 percent of homeless individuals need programs to help them recover from drug and alcohol-related illness. Treatment services for the homeless will be increased to $16 million in FY 2002 (+22%). CMHS will work with HRSA-funded Community and Migrant Health Centers to conduct outreach and engage homeless individuals with mental illness and co-occurring substance abuse disorders.

SAMHSA will also double the substance abuse treatment investment to $12 million for persons who are re-entering the community from prisons, jails, or detention centers. These projects are crucial for developing systems linkages and referral resources, increasing treatment capacity, and providing ancillary services such as assessment, case management, education, and aftercare.

> The U.S. rate of incarceration is growing by approximately 7% each year and drugs are implicated in the incarceration of 80% of the people in jail. Studies show that only 27% of offenders who receive treatment in prison and after, return to jail, compared to 75% recidivism for offenders in comparison groups.

Finally, all three Centers will continue efforts to assist racial and ethnic minority communities which are disproportionally affected by HIV/AIDS. Over the past several years, SAMHSA resources dedicated to this particular effort have grown to $92.1 million; total SAMHSA resources for HIV/AIDS programs are estimated at $157.9 million in

FY 2002, including those expended through the Substance Abuse Block Grant. The program is helping to demonstrate new and innovative strategies to address such problems as the increasing number of cases attributable to injecting drug use among African Americans.

Because 50 percent of new HIV/AIDS cases result from substance abuse behaviors, as do 30 percent of all AIDS cases, it is fair to say that substance abuse prevention represents effective HIV/AIDS prevention as well. In this regard, nearly all of CSAP's program can be viewed as contributing to SAMHSA's overall HIV/AIDS program. CSAP is bringing its prevention expertise to communities to help stop the increase of HIV infections in minority and other communities.

CLOSING SERVICE GAPS

The service gaps identified above will continue to be addressed in FY 2002 through SAMHSA's core service efforts: Targeted Capacity Expansion, the Children's Mental Health Service program, the Mental Health Block Grant, and the Substance Abuse Block Grant. Services supported through these programs are increasingly encouraged to employ best practices identified by the Agency, and to document performance through evaluations, outcome measurement, and reporting of core data. As with best practices, the manner in which the Agency conducts programs has changed materially over the past several years, and future changes are imminent. SAMHSA is currently considering performance partnership approaches which, if adopted, would involve significant changes in the State-federal relationship in supporting mental health and substance abuse service delivery.

Mental health service programs will be continued at the current level in FY 2002, including those requested for State Block Grants, except for $15.9 million provided for one-year congressionally earmarked projects concluding in FY 2001. Updates in the distribution formula related to population and taxable State resources will result in small increases and decreases in State allocations in FY 2002**.** CMHS will also continue the Targeted Capacity Expansion program, "Building Mentally Healthy Communities," initiated in FY 2001, with the requested $26.9 million. This program will assist cities, counties, and Tribes to provide the services necessary to address serious local or regional mental health problems through evidence-based prevention or treatment.

In the area of substance abuse prevention, the State Incentive Grant (SIG) program is a highly efficient mechanism for enhancing State capacity with high quality prevention services. CSAP will continue the SIG program by awarding grants to three additional States. Combined with the 9 new awards this year, a cumulative total of 40 States will have provided prevention services to nearly 2,700 communities and 1.2 million participants through 2002. States have achieved dramatic results through this program by filling gaps in the existing substance abuse prevention system.

There are currently over 2.9 million individuals in the U.S. with severe drug dependence who still need treatment. The FY 2002 President's Budget request includes an increase of $100 million over FY 2001 for substance abuse treatment. This investment recognizes both the need to address the continuing social and economic toll of substance abuse on the Nation as well as the proven effectiveness of substance abuse treatment. The President's initiative will allow States and local communities to provide treatment services to approximately 437,000 individuals, an increase of 16,500 (3.9%) over FY 2001. The initiative includes $60 million for States within the Substance Abuse Prevention and Treatment Block Grant (SAPT Block Grant), and $40 million for 54 new

Targeted Capacity Expansion grants to respond to both emerging and chronic treatment needs which might not be readily addressed with Block Grant funds.

The Targeted Capacity Expansion aspect of this initiative is comprised of five discrete components. These include:

- A treatment services component for teens and young adults. Only one in five adolescents in need of treatment is now estimated to access it. Treatment capacity will be established which includes the appropriate level and intensity of care, and will focus on efficacious treatment for adolescent alcohol abusers and alcoholics.
- Expanded capacity in the area of adult and juvenile drug courts. This will support new, clinically-based treatment and related services to address the gap in available drug court treatment services.
- Re-entry programs for adolescents returning from detention facilities. Over one-half of these young persons are substance abusers or substance dependent. This component will be conducted in cooperation with the Departments of Labor and Justice.
- Substance abuse treatment services for the homeless. This effort will strengthen the treatment infrastructure and help provide a continuum of care.
- Treatment services for the general population.

IMPROVING DATA SYSTEMS AND MANAGEMENT

The availability of accurate, reliable, and timely data on all aspects of mental health and substance abuse is critical to all of SAMHSA's efforts. National data are used by professionals throughout the country, as well as within the Agency, to spot trends, identify State or regional problems, tailor appropriate responses, and measure results. They are extremely valuable to SAMHSA's federal, State and local partners in service delivery. SAMHSA's data systems represent a valuable resource of historic trend data which permit detailed, in-depth analyses of the nature of the problems faced. Such information as the current drugs of abuse, the demographics of mental illness, changes in the age of onset of tobacco use, and racial/ethnic aspects of mental health and substance abuse all derive from SAMHSA data programs.

The FY 2002 budget proposes several changes in SAMHSA's data programs. First, $12.0 million formerly budgeted for ongoing operation of the National Household Survey on Drug Abuse (NHSDA) within the Program Management account is proposed for transfer to the Secretary's one percent evaluation funding. This is consistent with evaluation support currently budgeted for other HHS data systems. In addition, three new data activities will be conducted with $17.0 million in evaluation resources. These include adding a longitudinal survey of 6,000 youth to the NHSDA to clarify the development of substance abuse problems in this cohort; adding an NHSDA component focusing on substance abuse in older populations; expanding the Drug Abuse Warning Network (DAWN) sample size; and adding a survey of treatment services in correctional facilities to the Drug and Alcohol Services Information System (DASIS).

Another aspect of SAMHSA's data program is newly authorized support for development of State data collection infrastructure. States vary widely in their ability to collect and report on key performance measures of their mental health and substance abuse programs. Data obtained cannot

be aggregated at the national level. CMHS is initiating an infrastructure program in FY 2001 to support awards to all States to improve their data efforts, and the program will be continued with $6.0 requested for 2002. CSAT will initiate a similar competitive State data program with $1.0 million in 2002. States are required to share costs under the fifty percent match requirement of the statute.

As noted above, SAMHSA staff resources will be maintained at the 2001 level in 2002. Most resources necessary to provide pay raise and other built-in increases will be derived from the non-recurring cost of a one-year project which ends in 2002.

Maintaining adequate staff support levels is essential to the Agency's ability to manage an increasing workload and program portfolio. New activities require consultation with internal and external partners, Tribal consultations, development and reporting of performance measures, integration of data systems, and translation and communication of results. To be done well, these and other necessary functions are staff-intensive. The recent growth and expansion of SAMHSA programs - from youth violence to fetal alcohol syndrome to drug courts - has demanded that SAMHSA recruit and retain a highly trained professional staff. Anticipated future retirements and projected losses due to normal attrition have prompted the Agency to engage in an extensive workforce planning analysis. This study is expected to result in a blueprint for assuring that SAMHSA continues to possess a well-trained, capable workforce in the future.

MENTAL HEALTH SERVICES
Overview

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
PRNS	$136,733,000	$203,674,000	$203,499,000	+$66,766,000	$187,599,000	-$15,900,000
Child MH	82,677,000	91,763,000	91,694,000	+9,287,000	91,694,000	—
P & A	24,903,000	30,000,000	30,000,000	+5,097,000	30,000,000	—
PATH	30,883,000	36,883,000	36,855,000	+5,972,000	36,855,000	—
MHBG	356,000,000	420,000,000	420,000,000	+64,000,000	420,000,000	—
Total, CMHS	$631,196,000	$782,320,000	$782,048,000	+$150,852,000	$766,148,000	-$15,900,000

SAMHSA's Center for Mental Health Services (CMHS) manages grant programs which improve the lives of adults who have serious mental illness and children with serious emotional disturbances. The CMHS serves as the federal focal point for knowledge development and application of research-based, community-focused mental health services, which represent the legacy of decades of work to create an effective community-based mental health service infrastructure throughout our Nation. The people most affected by the work of CMHS include some of the Nation's most underserved and at-risk populations over their life span, such as racial/ethnic minorities, women, young children and their families, older adults, those who suffer from disasters, individuals who are homeless, and refugees.

GPRA goals:
- Assure service availability
- Meet unmet and emerging needs
- Bridge the gap between knowledge & practice
- Strengthen data collection to improve quality & enhance accountability

The President's New Freedom Initiative recognizes that providing community-based care for persons with disabilities is critical in promoting their maximum independence. This Initiative is synergistic with CMHS efforts to tear down the barriers that face many Americans with disabilities and support fully integrated community-based service settings for individuals with disabilities.

In 1996, the World Health Organization (WHO) issued a landmark document, *The Global Burden of Disease*, which quantified the overall burden of disease from all causes. This report identified mental illness as the second leading cause of disability and premature mortality in the United States. Collectively, mental disorders account for more than 15 percent of the overall burden of disease from all causes, slightly more than the burden associated with all forms of cancer. In 1996, economists indicated the direct costs of mental health services in the U.S. were $69 billion with indirect costs being $78.6 billion. More than 80 percent of these indirect costs result from disability, not death, and

are associated with lost productivity at work, school, and home - areas targeted by SAMHSA's prevention and health promotion agenda.

The first Surgeon General's Report on Mental Health published in December 1999, estimates that 22 to 23 percent of the U.S. adult population or 44 million adults have diagnosable mental disorders during any 12-month period.

This report further confirms that although more than one in five Americans experiences a mental disorder during the course of a year, nearly half of all Americans with a severe mental illness do not seek treatment. Additionally, a range of 25 to 40 percent of the individuals with a mental illness will have some contact with the criminal justice system, while 16 percent of all individuals incarcerated in State and local jails have a serious mental disorder. Of the 600,000 individuals who are homeless on any given night, approximately one-third have a severe mental illness. Equally alarming are the suicide statistics with approximately 30,000 Americans committing suicide annually, including 4,500 children and adolescents. Furthermore, the Surgeon General's report estimates there are 6 to 9 million children and adolescents in the United States with serious emotional disturbance, with about 20 percent of children having mental disorders with at least mild functional impairment.

According to the Surgeon General's Report, members of diverse ethnic-cultural groups are less likely to receive appropriate mental health care than are members of the population as a whole. Similar disparities have been identified in other health care areas. A Federal priority is to reduce disparities in both mental and physical health and health care throughout the Nation. A supplement to the Surgeon General's 1999 Report on Mental Health will summarize available knowledge with regard to unmet need for mental health care of ethnic/culturally diverse groups within the U.S. and will discuss promising directions for improving research and services to diverse populations.

The Surgeon General's Report highlights a strong consensus among Americans of all walks of life that our society no longer can afford to view mental health as separate and unequal to general health. It cites extensive research that supports the effectiveness of mental health treatment and the availability of a range of treatments for most mental disorders. The Surgeon General's report acknowledges that despite the effictiveness of treatment options, half of all Americans who have severe mental illness do not seek treatment. Stigma associated with mental illness is identified as the foremost reason for such reluctance to seek treatment. Stigma erodes confidence and it leads people to avoid socializing, employing or working with or living with or near persons with a mental disorder.

'Youth Violence: A Report of the Surgeon General' released January 17, 2001, states that the youth violence epidemic is not over and that effective prevention programs exist. According to the Surgeon General, "The most urgent need now is a national resolve to confront the problem of youth violence systematically using research-based approaches and to correct damaging myths and stereotypes

Selected Findings on Youth Violence

1. Youths who commit violence before age 13 generally commit more crimes and more serious crimes for a longer time
2. The most highly aggressive children or children with behavioral disorders do not become serious violent offenders
3. 30% - 40% of male youth commit a serious violent offense by age 17
4. 15%-30% of female youth commit a serious violent offense by age 17

that interfere with the task at hand. ... This report confirms that, as a nation, we possess knowledge and have translated that knowledge into programs that are effective in preventing youth violence. ...Therefore, we cannot afford to waste resources on ineffective or harmful interventions and

Children and Violence

CMHS is fully committed to the prevention of youth violence and the promotion of healthy development and to intervene with families, schools, and communities where violence has already occurred. The Center has developed many violence prevention and treatment programs, such as the interagency partnership with the Departments of Education, Justice, and Labor (Safe Schools/Healthy Students Program), and promotes comprehensive, integrated, community-wide strategies with the goal of fostering school safety and healthy youth development. School and community mental health preventive and treatment interventions are core ingredients of this effort.

The CMHS website (http://www.samhsa.gov or http://www.mentalhealth.org) contains full program descriptions and grant opportunities for schools, community groups and others to obtain Federal assistance.

strategies-or to further jeopardize the well-being of youth who may be assigned to ineffective programs."

In December 2000, the Government Accounting Office released to the U.S. Senate Committee on Finance, a report entitled, "Community-Based Care Increases for People with Serious Mental Illness." This report validated SAMHSA's approach by recognizing the need for community-based services that give ongoing support to adults with serious mental illness (SMI). The report concludes, "These services are especially critical for people making the transition from institutions to the community, to help prevent their becoming homeless or returning to institutions. ...homeless people with SMI especially need to receive a range of mental health, substance abuse, social support, and housing services to function in the community, and it is important for providers to link these services effectively."

As a Nation, we have the knowledge to respond effectively and respectfully to the needs of persons with mental illness yet, there is a lack of consistent attention to the promotion of mental health and prevention or worsening of mental illness. The lingering stigma and discrimination attached to individuals with mental illness contribute to the myth that people do not recover. Until recently, sufficient evidence on effective science approaches was sparse. We

Core Client Outcomes are:

- ✓ Reduced Use of Alcohol or Illegal Drugs
- ✓ Stable Living Environment
- ✓ Attending School
- ✓ Employed
- ✓ Reduced contact with Criminal Justice System

now know that promotion, prevention, treatment and recovery are inextricably linked. The good news is that people who once were thought to be on a deteriorating, chronic course are now holding jobs, living in the community, getting and staying married, and fully participating in our society. As stated in the Surgeon General's Report, the majority of individuals with mental illnesses now can be successfully treated. CMHS will meet the challenge to engage and keep people in treatment, while ensuring high quality, culturally and linguistically appropriate, least restrictive services for individuals with mental illness and work simultaneously with families and other caregivers, providers, educators, researchers, and others. The FY 2002 budget builds upon findings in the 1999 and 2001 Surgeon General's Reports, as well as successfully funded programs and Healthy People 2010 nationwide goals.

The mental health service system in the United States represents a complex connection of many competing components, including specialty-general health, health-social welfare, criminal and juvenile justice, education, housing, public-private sector payors, and others. Consequently, care may be fragmented and compartmentalized, and create barriers to access. Coupled with this complexity is the financing of services that often comes from different, opposing sources resulting in competitive funding incentives. The Surgeon General's Report confirms that the current service delivery system does not reflect our research-based capabilities to identify, treat, and at times, prevent mental disorders. This Administration will establish a Commission to review the mental health service delivery system to address these concerns.

Through diverse and emerging prevention, treatment and recovery strategies, SAMHSA will continue to improve access to quality mental health care services. One recent event having a profound influence on access is the Supreme Court decision in Olmstead v. L.C., 119S.Ct.2176 (1999), which interpreted Title II of the Americans with Disabilities Act (ADA) and established that unnecessary segregation of individuals with disabilities in institutions - including State psychiatric and other long term care facilities - constituted discrimination. To remedy this discrimination, the court found that the ADA requires States to serve people with disabilities in community-based settings when appropriate and reasonable. This ruling affects individuals who had been institutitionalized and at-risk of re-institutionalization, as well as individuals who are at-risk of institutionalization because of the lack of community-based services.

Having multiple "portals of entry" to treatment must not remain a barrier to access. Accordingly, SAMHSA will continue to ensure services through all doors; "Every door... an open door" can exist when primary health care, schools, child welfare, and other systems. The stigma that follows individuals seeking mental health services can be overcome as SAMHSA advances linguistically and culturally competent services that will ensure "a system for all."

Advances in mental health have yielded extraordinary understanding of mental illness and the accompanying services required for treatment, preventive intervention, and recovery. SAMHSA continues to work to affirm mental health as the cornerstone of health so that consumers of mental health services will be assured of consistently high quality, culturally appropriate and respectful, affordable, accessible, community and evidenced-based services.

Center for Mental Health Services
Mechanism Table
(Dollars in Thousands)

	FY 2000 Actuals		FY 2001 Current Estimate		FY 2002 Estimate	
	No.	Amount	No.	Amount	No.	Amount
PROGRAMS OF REGIONAL & NATIONAL SIGNIFICANCE						
Grants/Cooperative Agreements:						
Continuations	184	$37,951	125	$36,054	326	$75,911
New/Competing	136	25,263	360	78,591	92	22,924
Supplements	(11)	3,068	(7)	2,620	—	—
Subtotal	320	66,282	485	117,265	419	98,835
Contracts:						
Continuations	25	57,599	18	69,058	25	70,647
New	94	11,708	127	14,200	79	16,134
Subtotal	119	69,307	145	83,258	104	86,781
Technical Assistance	40	474	40	476	40	483
Review Cost	1	670	2	2,500	1	1,500
TOTAL, PRNS	***480***	***136,733***	***672***	***203,499***	***564***	***187,599***
CHILDREN'S MENTAL HEALTH						
Grants/Cooperative Agreements:						
Continuations	45	60,864	46	71,217	46	61,986
New/Competing	2	1,675	—	—	8	8,304
Supplements	—	—	—	—	—	—
Subtotal	47	62,539	46	71,217	54	70,290
Contracts:						
Continuations	10	13,314	11	12,578	6	12,487
New	12	6,155	12	7,530	16	8,248
Subtotal	22	19,469	23	20,108	22	20,735
Technical Assistance	8	369	8	369	8	369
Review Cost	1	300	—	—	1	300
TOTAL, CHILDRENS	***78***	***82,677***	***77***	***91,694***	***85***	***91,694***
MENTAL HEALTH BLOCK GRANT	***59***	***356,000***	***59***	***420,000***	***59***	***420,000***
PATH	***56***	***30,883***	***56***	***36,855***	***56***	***36,855***
PROTECTION AND ADVOCACY	***56***	***24,903***	***57***	***30,000***	***57***	***30,000***
TOTAL, CMHS	***729***	***$631,196***	***921***	***$782,048***	***821***	***$766,148***

CENTER FOR MENTAL HEALTH SERVICES
1. Programs of Regional & National Significance (PRNS)

Authorizing Legislation - Section 501, 520, 581, 582 and 1971 of the PHS Act.

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
Best Practices	$58,516,000	$61,878,000	$61,720,000	+$3,204,000	$54,660,000	-$7,060,000
TCE	—	35,014,000	35,014,000	+35,014,000	26,939,000	-8,075,000
Child & Violence	78,217,000	90,000,000	90,000,000	+11,783,000	90,000,000	—
Child & Trauma	—	10,000,000	10,000,000	+10,000,000	10,000,000	—
State Data Infrast	—	6,782,000	6,765,000	+6,765,000	6,000,000	-765,000
Total	$136,733,000	$203,674,000	$203,499,000	+$66,766,000	$187,599,000	-$15,900,000

2002 Authorization ..... Such Sums as Necessary

Purpose and Method of Operation .....

CMHS addresses priority mental health care needs of regional and national significance through developing and applying best practices, training and technical assistance, targeted capacity expansion and changing the service delivery system through family, client-oriented and consumer run activities.

CMHS accomplishes its mission of improving services for persons with or at risk of mental illness by using a comprehensive strategic approach to service development. The strategy provides for three broad steps: (1) developing an evidence base about what services and service delivery mechanisms work; (2) promoting community readiness to adopt evidence based practices; and (3) supporting capacity development.

A. Developing and Applying Best Practices

Since inception of the Knowledge Development and Application (KDA) program in 1996, a number of important advances have been made:

1. Mental Health Knowledge Development portfolio has diversified and matured. We now understand:

- Medicaid Managed Care affects delivery of services to children with Serious Emotional Disturbance and adults with Serious Mental Illness populations;
- The effectiveness of selected methods for avoiding homelessness among seriously mentally ill populations;
- The effectiveness of mental health interventions for homeless families, and in particular, treatment for homeless mothers and how it impacts their children;
- The impact of the supported housing model compared to traditional group living arrangements;

- The effectiveness of various diversion mechanisms that engage persons involved in the criminal justice system in integrated treatment for co-occurring disorders;
- How to reduce HIV risk in at-risk populations, and in particular, women and young adults;
- The complementary effects of consumer-operated self-help programs when added to mainstream mental health services;
- The effectiveness of integrated mental health, substance abuse and trauma services for women who have been physically and/or sexually abused;
- The effectiveness of integrated treatment versus specialty referral for elderly persons needing mental health or alcohol abuse treatment who were identified in the primary health care system; and,
- The effect of HIV/AIDS Mental Health integrated treatment on treatment adherence, health outcomes, and overall costs.

The CMHS portfolio responds to the vast array of information most needed to improve services for the Nation's most vulnerable and least-served populations. Findings from these programs are currently being used throughout the country to strengthen the treatment services delivery system.

Program to Prevent Homelessness resulted in:
✓ *Fewer Days Spent Homeless*
✓ *Greater Reductions in Symptomatology*
✓ *Improved Quality of Life*
✓ *A Model Way to Eliminate Homelessness* (Consumer Preference Independent Living)

Additional studies are nearing completion:

- The *Jail Diversion Study*, comparing the effectiveness of pre- and post- booking diversion programs at 9 sites located across the United States. Notable programs are the Memphis, Tennessee "Crisis Intervention Trained" police officer model and the Maryland "Phoenix Project" model for women and their children. A "Policy Analysis Committee" has been formed to examine the role of diversion in increasing access to care, and the effect of coercion on short-term outcomes.

- The *Employment Intervention Demonstration Program* has completed data collection and is now the largest existing database on ways to help people with serious mental illness work. As the Ticket to Work and Work Incentives Improvement Act of 1999 is implemented, this high-quality, comprehensive database on supporting working people with psychiatric disabilities provides a national treasure of information. During this program, participants earned over $5 million and contributed over 863,000 hours of productive work to the Nation's economy, demonstrating that people with the most severe and persistent mental illnesses are able to work and be productive citizens.

- *Evaluation of Housing Alternatives Program* examines the effectiveness of different housing approaches for persons with serious mental illness comparing the effectiveness of housing alternatives and the effects of housing on residential stability and resident satisfaction.

- The *Consumer-Operated Services Program* (COSP) evaluates the extent to which mental health consumer-operated services (COS) are effective in improving the outcomes of adults with serious mental illness when used as an adjunct to traditional mental health services (TMHS). Its multisite design includes randomization of participants to either COS plus TMHS or TMHS alone. (The largest study of its kind with many features built into the design to ensure a high level of scientific rigor. CMHS has also made considerable progress creating productive partnerships among consumers, service providers, and researchers.)

- *PRISMe: Primary Care Research In Substance Abuse & Mental Health Services for the Elderly* is evaluating alternative models of delivering and financing mental health and/or substance abuse services for older adults through primary health care. By the end of May 2001, over 50,000 individuals over 65 will be screened in primary care settings for MH/SA problems. Four Federal agencies are actively collaborating on this program bridging mental health, substance abuse, primary health and aging: SAMHSA, the Department of Veterans Affairs, the Health Care Financing Administration, and the Health Resources and Services Administration.

2. Knowledge application tools have been created and tested.

CMHS has supported service improvement in more than 100 specific communities. Through the Community Action Grant Program, CMHS is supporting 104 projects in 37 States that are working hard to put evidence-based practices into use for people with mental illness and children with serious emotional disorders. This program continues the service improvement strategy of supporting local sponsors of services to build consensus and elicit decisions to implement exemplary practices.

> Local communities are best able to identify evidenced based practices that work for them, adapt them to meet their needs, overcome all barriers to implementation of these practices and to implement and support these practices through local resources.

Some of examples of these innovative and highly successful projects include:

Courts Systems - In the State of Texas, the legislature is currently considering bills to improve the quality and effectiveness of insanity evaluations; to divert mentally ill persons from the court system into the treatment system; and to create a taskforce appointed by the Lieutenant Governor to review the methods and procedures used to evaluate a criminal defendant's competency to stand trial.

Homelessness - In San Mateo and Marin, California, people who are homeless and mentally ill are receiving multidisciplinary and integrated services that link them to decent housing, health care, treatment, and supportive services.

Children and Adolescents - In Tampa, Florida, the Family Services Association, the Hispanic Services Council, and the Louis de la Parte Florida Mental Health Council at the University of

Florida are implementing a System of Care model for Hispanic children with serious emotional disturbance and their families. The Georgia Parent Support Network, Inc. has joined the Mental Health Association of Georgia to implement WrapAround Services for children with serious emotional disturbance and their families.

Knowledge Exchange Network

The CMHS National Knowledge Exchange Network provides a wide range of information about mental health treatment and services to consumers, their families, the general public, policy makers, providers, and researchers. Since an estimated 50 million Americans experience a mental disorder in any given year and only one-fourth of them actually receive services, making information available is critical to help them seek and get the help they need.

Requests for information have increased dramatically over the past 5 years, as have CMHS web training sessions (see figures 1 and 2). Our goal is to increase the number of web sessions and information requests by 10 percent per year. For more information, see the Government Performance

Figure 1

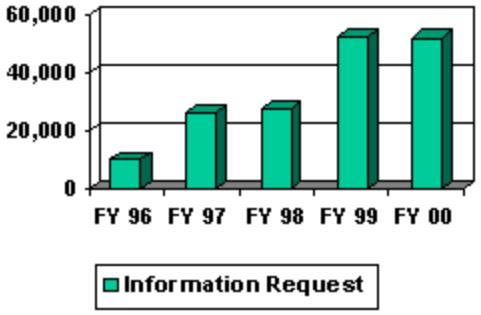
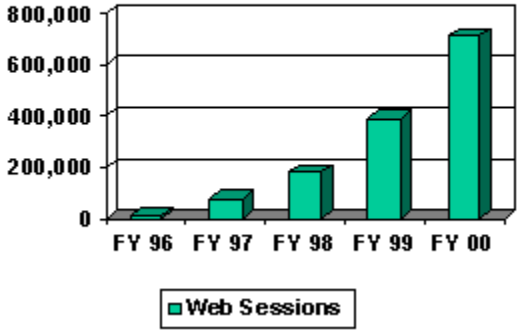


Figure 2



and Results Act section.

State Mental Health Plans

Together with the *National Association of Mental Health Planning and Advisory Councils,* CMHS plans to disseminate knowledge development findings and provide technical assistance to planning and advisory council members across the country to ensure state-of-the-art mental health plans are developed in each State. Topics of brochures for 2001 are *Co-Occurring Substance Abuse and Mental Health Disorders* and *Employment for Persons with Psychiatric Disabilities.*

Tool kits

CMHS is also developing *Evidence-Based Tool kits* to encourage mental health providers to adopt evidence- based treatments in clinical settings. Six tool kits will be developed by teams of experts in the practice areas of: 1) Assertive Community Treatment, 2) Supported Employment, 3) Medication Algorithms, 4) Family Psychoeducation, 5) Illness Self-Management Training, and 6) Integrated Substance Abuse and Mental Health Treatment. Each tool kit team is advised by a consensus panel composed of mental health consumers, providers, administrators, and medical records/quality improvement specialists. Consumer materials will be made available in both English and Spanish.

Technical assistance has been provided to thousands of communities, programs, providers, consumers and families:

- The National Technical Assistance Center for Children's Mental Health continues to make significant advancements in the children's mental health field. Included in their accomplishments are: a 1,700 participant System of Care Institute focused on developing and emerging policy in Children's Mental Health; a Policy Academy attended by 5 State delegations to help develop policy strategies; and two Leadership Academies held with parent/professional leaders within the Comprehensive Community Mental Health Services for Children and Their Families Program. Finally, a new Promising Practices Document was developed focusing on maximizing the use of data to promote the community-based Systems of Care for children who have mental health disorders.

- The Statewide Family Network Program has given families a voice in providing services to their children. These grants have three goals toward which each of the grantees are working:

    1. Strengthening Organizational Relationships. Supporting the involvement of families at 171 policy tables across the country, grantees have demonstrated their dedication to this goal by:
        - 18% report work on addressing issues of seclusion and restraint
        - 25% report work on custody relinquishment
        - 32% report work on support of mental health parity

    2. Fostering Leadership and Management Skills. Grantees have attended the "Leadership Academy" through Georgetown University and used the strategies learned to increase State funding for cultural and ethnic minority outreach; publishing materials in various languages and formats; using translators; and recruiting trainers from all ethnic and socioeconomic communities.

    3. Transferring Knowledge. Statewide Family Network funds have improved existing products such as brochures, newsletters, and websites and provided resources for greater distribution. Grantees have sponsored and/or co-sponsored 142 conferences with funding from the Statewide Family Networks.

Consumer-run technical assistance centers have helped thousands get their voices heard. These centers provide assistance through various ways.

- One center conducted an exemplary Leadership Academy in 14 States, serving approximately 550 individuals. Five of those States have been west of the Mississippi. Seven States have participated in educating at least 80 potential trainers for their own future Leadership Academies. Of these States, five have conducted subsequent training. With ongoing assistance, three States have formed Statewide networks: Massachusetts, Maine, and Virginia. Eight States have worked with the centers to develop their vision, mission, and values statements.

- Another center distributed over 900 copies of its peer support manual and conducted peer support training in two States. Thirty seven individuals were trained as enhanced peer-support facilitators and each of them will be a resource for on-site peer-support efforts.

- Another center developed the Personal Assistance in Community Existence (PACE) program based on the Empowerment Model of Recovery. This center has written and distributed a PACE manual and has given PACE/Recovery training to consumers, family members, professionals and lawmakers in 15 locations across the country. States such as New York, California, Texas, Colorado, and Connecticut are working towards setting up PACE programs. Interest in starting PACE/Recovery programs is growing throughout the U.S., Canada and Europe.

- It is typical for centers to process approximately 200 requests per week for topic-based tool kits. Tool kit topics include: Advance Directives, Recovery and Empowerment, How To Start a Peer Support Group, and How to Organize and Run a Consumer Conference. One technical assistance center website contains a variety of articles as well as a means of ordering materials. There are an average of 35,000 visits per month to the website and the newsletter has a readership of 45,000. This center distributed 25,000 audiotapes of workshops, keynote speeches and institutes from the annual national consumer conferences, Alternatives. The most recent Alternatives 2000 conference was attended by 600 consumers, representing 40 States and 7 countries. Products from the centers have been translated into Spanish, Hebrew, French, Hungarian and Japanese.

CMHS contributes to the Nation's response to HIV/AIDS through education and services. SAMHSA/CMHS will continue the *Treatment Adherence, Health Outcomes, and Associated Costs Program*, a collaborative effort with HRSA, NIMH, NIAAA and NIDA, through FY 2002. Three major professional organizations received CMHS support to assure that mental health professionals are appropriately trained to address the psycho-social and the neuropsychiatric aspects of HIV/AIDS. In addition, a new five year direct services HIV/AIDS program supports community-based efforts to provide direct mental health services for people living with HIV/AIDS, especially people of color. This direct services program has a training component that targets both traditional and nontraditional mental health care providers, and, again, will target primarily the needs of people of color.

Lessons learned are being put into practice in Criminal Justice. A number of activities are applying the knowledge gained from programs that divert individuals with mental illness and substance abuse from jail and of other successful efforts to help people with these dual disorders reenter the community after being incarcerated. A group of national mental health organizations is using this knowledge base to develop strategies for implementing evidence based treatment models for mentally ill offenders. Lessons learned about jail diversion programs are being incorporated into technical assistance and training strategies and in the implementation of both pre-booking and post-booking diversion programs. Other lessons learned are used in the development of reentry programs supported by the Department of Justice.

In FY 2001, another round of three year **Circles of Care** grants supported American Indian/Alaska Native tribes to develop strategies for improving mental health services to Native children. Also, CMHS initiated a new three year grant program to certify and evaluate the effectiveness of **suicide hotlines**.

B. Training

In FY 2001, CMHS launched a new program entitled *Exemplary Alternatives to Seclusion and Restraint of Children & Youth*. This program provided $2,000,000 to demonstrate and evaluate the appropriate use of seclusion and restraint as well as establish a technical assistance center for a 3-year period. The nine sites are required to demonstrate the effectiveness of exemplary alternatives in the use of seclusion and restraint in mental health programs serving children and youth by using existing practices or newly developed ones. A resource manual that describes the appropriate use of seclusion and restraint developed by the demonstration sites will be published and distributed to child and youth mental health programs.

The Children's Health Act of 2000 changed the *Minority Fellowship Program* (MFP) in two ways: (1) eliminated the payback requirement for new students and; (2) post doctoral students are now eligible for support. The MFP facilitates both the entry of ethnic minority and other students into mental health careers and increases the number of nurses, psychiatrists, and social workers trained to teach, administer, and provide direct mental health and substance abuse services to ethnic minority groups. SAMHSA is committed to services that are professional, competent and effectively meet the critical mental health and substance abuse prevention and treatment needs of the Nation's diverse population.

C. Targeted Capacity Expansion

In FY 2001, CMHS started a new effort entitled, "Building Mentally Healthy Communities," designed to increase the capacity of local communities to provide prevention and treatment services to meet emerging, unmet mental health needs. The program helps cities, counties and tribal governments to provide the services necessary to address serious local or regional mental health problems through evidence-based prevention and treatment interventions. Priority populations include: infants, toddlers, preschool and school-aged children and adolescents; homeless adults and families; persons with co-occurring serious mental illness and substance abuse disorders; adults in the criminal justice system and/or in jail diversion programs; and youth in the juvenile justice system with emotional or psychological problems and/or behavioral disorders. Within this program $2.5 million is set-aside for projects targeting a reduction in racial/ethnic disparities in the availability of and access to mental health services, a significant problem highlighted by the Surgeon General's Report on Mental Health and the Healthy People 2010 mental health goals.

Also, CMHS provided support to the Department of Justice, Bureau of Justice Assistance for their re-entry program. This program provides services to adults with serious mental illness who are departing the criminal justice system.

D. Children and Violence

In February 2001, the Surgeon General published a report titled *Youth Violence: A Report of the Surgeon General (2001).* According to this Report, youth violence is a high-visibility, high-priority concern in every sector of U.S. society. No community, whether affluent or poor, urban, suburban, or rural, is immune from its devastating effects. Research clearly demonstrates that prevention programs and strategies can be effective against both early- and late-onset forms of violence in general populations of youths, high-risk youths, and even youths who are already violent or seriously delinquent. Most highly effective programs combine components that address both individual risks and environmental conditions, particularly building individual skills and competencies, parent effectiveness training, improving the social climate of the school, and changes in type and level of involvement in peer groups.

A central component of CMHS' youth violence prevention effort is the "Safe Schools/Healthy Students" program, a collaborative effort of the Federal Departments of Education, Justice, Labor and Health and Human Services. Beginning in September 1999, individual grants of $1 to $3 million were awarded to 54 local education authorities that have forged unprecedented, formal partnerships with local mental health and law enforcement agencies. Through these partnerships, comprehensive plans are being implemented to promote healthy development, foster resilience in the face of adversity, and prevent violence. The plans cover six primary areas: (1) school safety, (2) alcohol and other drug and violence prevention and early intervention programs, (3) school and community mental health prevention and treatment services, (4) early childhood psychosocial and emotional development programs, (5) education reform, and (6) safe school policies. An additional 23 sites were funded in FY 2000 and, in FY 2001, CMHS funded 22 new sites. The demand and competition for participation in the program has been tremendous; solicitations for the program have resulted in hundreds of applications, pointing to the willingness, readiness, and commitment of schools and communities to mobilize around addressing the complex problem of violence among youth.

CMHS takes a multi-level approach to addressing the youth violence crisis. Through its Youth Violence Prevention Grant program, CMHS supports communities, including faith-based organizations, around the country to implement and evaluate programs designed to prevent violence and suicide, and promote healthy mental development in their schools. This program requires grantees to first build community-based consensus and collaboration in order to be able to establish, implement, and sustain evidence-based youth violence prevention programs.

In order for collaborative, community change efforts to be successful, we must also develop and bring together public service systems that support healthy development in youth, neighborhoods, and communities. In FY 2000, CMHS awarded grants to States and local governmental entities to promote mental health and prevent violence and substance abuse among youth. The grants support the development of self-sustaining coalitions between State and local governments with community service delivery systems, in order to promote community-wide understanding of youth problem behaviors and approaches to violence prevention. The grants also assist communities in assessing youth behavioral problems, identifying risk and protective factors for such problems, and evaluating the availability of and gaps in needed services.

In addition to involving families in school programs, it is also critical that parents make time at home to communicate on a regular basis with their children. Over 12,000 high school youth were interviewed about their violent behavior, delinquency, substance abuse and school failure. They identified two crucial factors significantly associated with youth staying out of trouble (1) a positive association with school and (2) a strong connection between parents and youth. Parents who talk with their children about what is happening in their lives are better able to guide their children toward more positive, skill-enhancing activities and friendships while imparting their family's values. Based on these findings of the School Violence Prevention Program, CMHS launched the communication campaign Make Time to Listen, Take Time to Talk, 15+ in partnership with WJLA-TV/7 in Washington D.C. The campaign is designed to provide practical guidance to parents and caregivers about how to create the time to listen and take the time to talk at least 15 minutes or more every day with their children.

The CMHS Emergency Services and Disaster Relief program is collaborating with the Department of Education on their new effort Project SERV - School Emergency Response to Violence - in FY 2001. CMHS will address the mental health services needed when a violent and traumatic incident occurs affecting a school community. CMHS will build upon its formal interagency agreements with the Department of Justice, Office for Victims of Crime and the Department of Veterans Affairs, National Center for Post Traumatic Stress Disorder to develop mental health response protocols, training, technical assistance and consultation to meet both the immediate and long term mental health needs of the impacted school communities.

Youth violence is a complex and persistent problem that requires a sustained commitment of attention, effort, and resources if it is to be ameliorated. Our nation's schools and communities have shown us that with the right partners and with comprehensive approaches, we can build strong communities and neighborhoods that support the healthy development of children and youth and prevent youth violence and suicide.

E. Children & Trauma

Much recent media attention has been paid to violent acts committed by youth, especially in schools, but relatively little attention has been paid to the effects the witnessing of violence can have on children and adolescents. Research on the differential effects of violence and various types of violence, as well as what treatment approaches work with children who have been traumatized by violence, is scant. However, there is clear evidence that exposure to or involvement in violence can disrupt normal development of both children and adolescents with profound effects on their mental, physical, and emotional health.

CMHS National Child Traumatic Stress Program will 1) improve the quality, effectiveness, and availability of therapeutic services delivered to traumatized children and adolescents, 2) further the understanding of the individual, familial, and community impact of child and adolescent traumatic stress and the methods used to prevent its consequences, and 3) reduce the frequency and consequences of traumatic events on children and adolescents through greater public recognition of the issue, deeper understanding of their sequelae, and improved prevention and treatment services.

F. State Data Infrastructure

The Children's Health Act of 2000 authorizes SAMHSA to implement a Data Infrastructure program which provides grants to all States and Territories for the purpose of improving their infrastructure capability to report uniform data, especially data collected on performance indicators.

One of the conditions for receiving a grant was that all States and Territories must agree to gather and report to CMHS uniform data as requested in the mental health block grant application effective fiscal year 2002. With these data, for the first time CMHS will be able to determine the gaps in the public service delivery system, capacity to provide the service, and the quality and effectiveness of the service provided.

Programs of Regional & National Significance
Program Distribution of Funds
(dollars in thousands)

	FY 2000	FY 2001	FY 2002
Homeless	$8,486	$9,890	$ 5,736
HIV/AIDS	7,980	11,118	13,035
Community Support Programs for Adults	22,615	33,415	24,261
Children, Adolescents & Their Families	10,774	24,931	23,001
Children & Violence	78,217	90,000	90,000
Local Service Expansion	—	9,021	9,021
Prevention/Early Intervention	—	5,510	5,510
State Data Infrastructure	—	6,765	6,000
Other	8,661	12,849	11,035
Total	$136,733	$203,499	$187,599

Funding levels for the past five fiscal years were as follows:

	Funding	FTEs
1997	$57,964,000	---
1998	57,964,000	—
1999	96,419,000	---
2000	136,733,000	---
2001	203,499,000	—

FY 2002 Priority Investments . . . . . .

The total amount available for new priority investments in FY 2002 is approximately $39 million. Of this amount, $18.7 million will be available for programs which develop and apply best mental health practices and $20.3 million will be used to augment the Children and Violence Program. These resources are available within the mental health services discretionary program as a number of projects conclude in FY 2001. Over the coming year, CMHS will continue to consult with its partners and stakeholders to assure that available resources are directed to meet the most pressing needs of the mental health community. The programs proposed for funding below reflect the current

professional judgement of the agency and its partners regarding the most pressing mental health program needs for FY 2002.

Developing and Applying Best Practices

CMHS will issue grant announcements for $18.7 million for the Community Action, Conference grants, Consumer and Consumer Supporter Technical Assistance Centers, Workforce Training, and Youth Transition Services grant programs for $11.3 million. Also contracts will be awarded in the areas of disaster consequences, consumer literacy, support for Best Practices, and other recurring program support activities. In addition, through interagency agreements, CMHS will collaborate with Health Resources Services Administration to support mental health services under the Community Health Centers and the Department of Education to continue support of the research and training centers. These contract activities will total an estimated $7.4 million.

Disaster Consequences

SAMHSA's long standing involvement in the response to the emotional consequences of natural disasters has repeatedly reinforced the importance of understanding and responding to the psychological effects of such events. Experience in Oklahoma City following this Nation's most significant terrorist crime has shown us that man-made disasters result in more frequent, longer lasting, and more severe mental health consequences. Terrorist incidents have an impact on persons and communities that are far greater than the loss of life and property might suggest. Yet, this same experience revealed the gaping deficit in our ability to predict, plan for and respond to the terrifying possibility of a biologic, chemical or radiologic terrorist act. More than five years later, the first responders to the Oklahoma City bombing still have continuing mental health difficulties.

There is every reason to believe the terrorist use of biologic weapons will impact the mental health of communities in a manner far greater and substantially different from that seen even in Oklahoma City. The behavioral health impact of a significant bioterrorist event will produce the most numerous, most long term, and most wide spread, and most expensive consequences of all health impacts. The subsequent modification of social, economic, and cultural patterns will likely be felt for generations.

In addition to natural disaster response training, in FY 2002, CMHS proposes to initiate a wide variety of consultations, training packages and hands-on training opportunities to States to heighten awareness and preparedness to the mental health effects imposed by the threat and reality of disaster consequences. In the future, CMHS will expand knowledge about the social and psychological ramifications of disaster consequences and disseminate findings and recommendations for action at the national, State and local levels. CMHS plans to award 2 contracts for a total of $1.0 million.

Consumer Literacy - Barriers to Treatment

The President's New Freedom Initiative will ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where to live and participate in community life. It will expand

Nearly 50 percent of all Americans who have a severe mental illness do not seek treatment.

An explicit recommendation from the Surgeon General's Report on Mental Health is '*seek help if you have a mental health problem or think you have symptoms of a mental disorder.*'

research in and access to assistive and universally designed technologies, further integrate Americans with disabilities into the workforce and help remove barriers to participation in community life.

Foremost among the barriers to treatment is stigma. The Nation needs to confront the attitudes, fear, and misunderstanding about mental health and mental illness. The Surgeon General's Report recognizes the growing role that consumers have in reducing stigma and improving service outcomes. In FY 2002, SAMHSA plans to spend $2 million to fight stigma and raise consumer literacy through education to take down the barriers to treatment.

In March 2001 CMHS is convening a national mental health symposium "Spring to Action" to address discrimination and stigma. The symposium is an opportunity to learn what works and what does not work on this issue, how exemplary practices can be disseminated and replicated, and what it would take to implement a national endeavor.

In FY 2002, CMHS plans to implement recommendations and suggestions developed at the March 2001 symposium to address discrimination and stigma; to develop and implement a Mental Health Public Awareness Campaign to demonstrate effective public awareness approaches on mental health issues; and to increase the knowledge and skills of mental health consumers to promote adequate, appropriate, and effective mental health services.

Community Health Center Project with the Health Resources and Services Administration
This project will build capacity within HRSA-funded Community and Migrant Health Centers to conduct outreach and engagement to homeless individuals with mental illness and co-occurring substance use disorders. In conjunction with a $100 million HRSA effort to expand mental health capacity in their Community and Migrant Health Centers, CMHS will provide $1.5 million of funding as well as technical assistance and program guidance regarding the implementation of effective strategies for meeting the mental health needs of individuals who are homeless and receiving health services in these public sector agencies.

Consumer and Consumer Supporter Technical Assistance Centers
CMHS staff met with consumers at the Alternatives 2000 Conference and with the CMHS National Advisory Council Sub-Committee on Consumer/Survivor Issues. As a result it is evident that there is a demand and need for regional and local technical assistance which is not being sufficiently met. In FY 2001, CMHS plans to review the technical assistance needs and implement an evaluation of the existing technical assistance response capability. In FY 2002, CMHS proposes a national competition for long term funding of consumer technical assistance centers and technical assistance to consumer supporters. CMHS plans to award 5 grants for a total of $2.0 million.

Workforce Training
According to the upcoming supplement to the Surgeon General's Report on Mental Health on Race, Ethnicity and Culture, ethnic and racial minority adults and children bear a disproportionate burden from mental illness and serious emotional disturbance. While racial and ethnic minorities continue to increase in absolute numbers and as a proportion of the general population (nearly 25%), the number of professionally trained minority mental health providers (approximately 8%) is not increasing at the same rate.

The goal of the workforce program is to develop strategies for building capacity in the public mental health system to serve racial and ethnic minority adults, children and families using state-of-the-art treatment approaches. This effort will target consumers, families and other para-professionals, students in non-traditional mental health training programs such as primary care residents, case managers, teachers, substance abuse counselors, and front line mental health providers (both professional and paraprofessional) already working in hospitals, managed care organizations or community-based agencies serving significant numbers of racial and ethnic minority adults, children and families. Six grants are planned for a total of $1.6 million.

Youth Transition Services
This program will support activities to coordinate and enhance existing mental health programs to facilitate linkages between the child and adult services systems of care. The target population of concern are adolescents and young adults ages 16-24 with a serious emotional disturbance (SED) and/or an emerging mental illness.

The transition between service systems for youth and young adults presents unique barriers that put these individuals at significantly greater risk for school failure, involvement with the criminal justice system and/or dependency on social services, including homelessness. These youth have the highest rates of dropout from secondary school among all disability groups. In addition, these youth experience alarmingly poor outcomes compared to the general population entering adulthood in the areas of post secondary education and later employment, increased arrests and incarceration, increased incidence of unplanned pregnancy and childbearing and decreased ability to live independently.

The transition period for youth and young adults with emotional/behavioral disorders is further complicated by the lack of coordinated services among children's mental health, child welfare, education, adult mental health, substance abuse treatment, housing and rehabilitation sectors. Young adults and families, professionals, and administrators from across the country, have voiced a number of consistent themes pertaining to the nature of the institutional transition and why it is so very difficult. These themes include:

- Institutional supports are withdrawn abruptly, often based on age alone.
- Institution-generated transition plans (IDEA) are weak, and are ultimately not followed.
- Continuity of care across child and adult institutions is lacking.
- Institutional supports are not young adult-centered.

States and political sub-divisions of States will be eligible to apply for funding to plan, design and assess a transitional services partnership plan. Grantees will engage in a strategic planning process, design a model for providing transitional services for youth with SED and conduct a feasibility assessment of the model. Six grants are planned for a total of $2.0 million.

Community Action and Conference Grants Programs
An estimated $5.7 million for 28 grants (one year awards) has been planned for these two programs for FY 2002.

Program Support Contracts

An estimated $2.9 million will continue to support recurring program support needs such as grantee consultation, evidence-based analyses, program evaluation contracts and collaboration with other federal agencies.

Children and Violence Program

Of the $20.3 million for the Children and Violence Program, CMHS will issue new grant announcements for the Youth Violence Coordinating Center, Youth Violence Prevention (formerly Community and School Action Grants), and the Coalition for Prevention grant programs for a total of 47 grants for $11.6 million. In addition, the interagency agreement with Department of Education will be increased to support additional Safe Schools/Healthy Students grant sites and a communications contract is also planned to support the Children and Violence program. This will maintain the Children and Violence program funding level at $90 million, the same as in FY 2001.

Rationale for the Budget Request . . . . . .

The President's Budget includes $187,599,000 for FY 2002, a decrease of $15,900,000 compared to the FY 2001 current estimate of $203,499,000. The State Data Infrastructure program is reduced by $765,000, which is based on the formula in the program authorization. The reduction includes $10.9 million in one-year congressionally earmarked projects which end after FY 2001. The remaining $4.2 million reduces the appropriation base for PRNS as projects conclude.

SAMHSA will submit a legislative proposal to expand the authorities for Children and Violence.

CENTER FOR MENTAL HEALTH SERVICES
2. Children's Mental Health Services Program

Authorizing Legislation - Section 565 of the PHS Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
Child MH	$82,677,000	$91,763,000	$91,694,000	+$9,287,000	$91,694,000	—

2002 Authorization . . . . . Such Sums as Necessary

Purpose and Method of Operation . . . . . .

The Comprehensive Community Mental Health Services for Children and their Families Program encourages the development of intensive community-based services for children with serious emotional disturbance and their families based on a multi-agency, multi-disciplinary approach involving both the public and private sectors.

Funds are available through grants to States, political subdivisions of States, territories, and Indian tribes or tribal organizations. Funds are used to build on the existing service infrastructure so that the array of services required to meet the needs of the target population is available and accessible. Grants are limited to a total of 6 years and grantees must develop sources of non-federal matching contributions which must increase over the term of the award from $1 for each $3 of Federal funds in the first year to $2 for each $1 of Federal funds in the final year. After six years, the expected non-federal contribution rises to 41 percent of all dollars. Appropriated funds also support technical assistance to the grant communities, a cross-site evaluation, and a communication/social marketing campaign.

From 1993-2001, CMHS has funded 67 grants in 43 States and supported services to a total of 46,633 children. However, the program served children in only 249 of the 3,142 counties in the United States (8%). Only a small proportion of the country has been exposed to the highly successful system-of-care services provided by this program.

The Comprehensive Community Mental Health Services for Children and Their Families Program has been the recipient of numerous awards which include the Hammer Award for Reinventing Government and the Mercury and NAGC Blue Pencil Competition Awards for outstanding achievement in professional communications.

Outcomes from the evaluation have been used to monitor the performance of the Children's Services program for CMHS's Government Performance and Results Act (GPRA) Plan. Results of selected GPRA performance measures are reported below. For more information, see the Government Performance and Results Act section.

Performance Measures	1997 Baseline	2000 Actual
Increase in referrals from non-mental health agencies	75%	78.1%
Increase in referrals from juvenile justice	9%	14.6%
Decreased days in inpatient-residential treatment	265 days	149 days
Decrease in instability of living arrangements	76%	26%

Findings from this program have been published and widely disseminated in peer-reviewed scientific journals, Congressional Reports and Promising Practices Monographs. Many of the findings are based on data obtained from a cross-site evaluation through December 31st, 2000. However, the Program has also learned key lessons. One of them is that system-of-care principles provide CMHS with a strong vision for system and services reform that States and communities across the country can implement.

To date, the 67 sites have generated 35% of matching funds against the total federal and non-federal contribution to systems of care, or approximately $155 million. This estimate is somewhat conservative given that the local contribution in some sites is much higher than 35%.

One grant community where the local contribution increased dramatically during the grant period was Wraparound Milwaukee. In 1996, the total spent on children's mental health services in Milwaukee was $4.3 million. In only two years, the children's mental health budget had increased to $31 million. By 1998, the federal CMHS contribution to the project was only 8% of total funds. Wraparound Milwaukee implemented with a high degree of success a public managed care approach to its service delivery system. To this day, the system of care in Milwaukee is fully sustained and serves as an important national model that many communities across the Nation seek to emulate. In February

KEY LESSONS LEARNED

CMHS-funded communities:

- have made an impact on local and State policy reform
- apply system-of-care principles to a greater extent than non-funded communities
- improve the functional and clinical outcomes of children and their families
- increase involvement of families and youth
- energize racial and ethnic communities to care for their children and families

2001, a group of 100 nationally-recognized stakeholders was convened to critique the effort and provide ideas for new directions. During this mid-course review meeting, family members, youth, policymakers, representatives of professional associations, advocates, providers, researchers, project directors, among many others, recommended that:

- clinical practices should conform to the preferences and cultural values of children and families;
- the involvement of children, youth, and families in systems of care must be clearly articulated and implemented;
- the cross-site evaluation needs increased focus with greater attention paid to the development of local evaluation capacity;
- cultural competence standards for systems of care need to be specified and implemented;
- federal cross-agency collaboration should increase to reduce barriers for system-of-care implementation and to pool existing federal resources for greater program impact;
- outcomes should be defined with input from communities and with increased attention to data elements derived from integrated cross-system information systems; and,
- sustainability of many systems of care can occur through their integration into comprehensive State plans.

CMHS' Child, Adolescent and Family Branch is already moving aggressively to implement many of the recommendations, in the belief that learning from experience, listening to new ideas, and implementing with renewed vision will increase the reach and effectiveness of the program.

Child and Family Characteristics. Among the children entering the service sites, 62 percent were male, 38 percent were female. The children's average age was 12.1 years. White children represented 68 percent of service recipients, while 19 percent were African American, 3 percent were Asian/Pacific Islander, 3 percent were Native American, 2 percent were Native Hawaiian, and 2 percent were classified as Other. Of all respondents, 20 percent were Hispanic. Among those children assigned a primary diagnosis, 29 percent had conduct-related disorders, 26 percent had depressive or dysthymic disorders, 14 percent had attention deficit or hyperactivity disorders, 8 percent had anxiety disorders, 6 percent had adjustment disorders, and 2 percent had psychotic disorders. The remaining 15 percent of the children were diagnosed with substance use, developmental/autism disorders, learning disability, personality disorders, abuse/neglect, and other classifications, or the primary diagnosis was deferred. With respect to family characteristics, children in custody of their mothers represented 49 percent of the sample, compared to a national average for mother-maintained households of 27 percent.

Child Outcomes. Findings indicate notable improvements for children after one year in services. For example,

- ***Law Enforcement Contacts Reduced.*** The proportion of children with no law enforcement contacts in the previous 12 months increased by 13 percent. At the same time, the percent of children with some law enforcement contacts in the previous 12 months decreased by 32 percent.

- ***Stable Living Arrangements Increased.*** The percent of children with multiple living arrangements decreased by 9 percent after one year. Similarly, the percent of children having a single living arrangement increased by 21 percent after one year.

- ***School Performance Improved.*** The proportion of children with below average or failing grades decreased by 23 percent after one year among both1993-1994 and 1997-1998 grantees, respectively. In addition, the percent of children with average or above average school grades increased by 18 and 30 percent after one year among 1993-1994 and 1997-1998 grantees, respectively.

- ***School Attendance Improved.*** The percent of children attending school infrequently (75 percent or less of the time) decreased by 21 and 41 percent after one year among 1993-1994 and 1997-1998 grantees, respectively. Regular attendance increased by 5 and 32 percent after one year among 1993-1994 and 1997-1998 grantees, respectively.

- ***Use of cigarettes, alcohol and illicit drugs decreased slightly.*** The proportion of children ages 11 through 18 who reported using cigarettes, alcohol or illicit drugs, including substances such as LSD, heroine, crack cocaine, powder cocaine, and amphetamines, in the 30 days prior to the survey period, decreased slightly from intake to two years after participation in services among 1997-1998 grantees. Marijuana use increased slightly. These differences were not significant.

Findings also suggested that the mental health of children who remained in services for an extended period of time continued to improve. For instance,

- ***Behavioral and Emotional Problems Improved.*** The percent of children with a reliable positive change in behaviors and emotions as assessed by parents was 23 percent after six months, and it increased to 32 percent after one year, and 37 percent after two years. Furthermore, the percent of children whose behavioral and emotional functioning did not change, was 70 percent after six months, and decreased to 60 percent after one year, and 56 percent after two years.

Family Outcomes. Findings show high family caregiver satisfaction and reduced caregiver strain as follows:

- ***Caregiver Ratings Remained High.*** The percent of caregivers who rated questions in the areas of service satisfaction, child's progress, ability to choose services, being asked own opinion of services, and receiving unconditional care remained in or close to the high range (i.e., 70-80 percent) at six months and at one year.

- ***Caregiver Strain Reduced.*** Caregivers reported significant reductions in self-related, environment-related strain, and child-related strain after six months.

Number of New Enrollees in the Children's Mental Health Service Program

Fiscal Year	New Enrollees Each Year	Cumulative
1994	3,610	3,610
1995	6,123	9,733
1996	8,821	18,554
1997	9,651	28,205
1998	11,045	39,250
1999	2,781	42,031
2000 est*	5,400	47,431
2001 est*	5,400	52,831
2002 est*	6,360	59,191

* These estimates are based on an average of 120 new children enrolled per site per year.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1997.....	$69,896,000	--
1998.....	72,927,000	--
1999.....	77,909,000	--
2000.....	82,677,000	--
2001.....	91,694,000	--

Rationale for the Budget Request . . . . . .

The FY 2002 President's Budget includes $91,694,000 for the Children's Mental Health Services Program, the same level of funding as in FY 2001. This amount will support the continuation of 46 grants and provide for 8 new and competing grants. At this level, the program will serve 960 newly enrolled children in 32 additional counties across the United States. It will also continue support for evaluation, technical assistance, and communication activities, promising more improvement in more places for more children and their families in the future.

CENTER FOR MENTAL HEALTH SERVICES
3. Protection and Advocacy Program

Authorizing Legislation - Section 102 of the PAIMI Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
P & A	$24,903,000	$30,000,000	$30,000,000	+$5,097,000	$30,000,000	---

2002 Authorization ..... Such Sums as Necessary

Purpose and Method of Operation .....

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program provides formula grant awards to protection and advocacy (P&A) systems designated by the governor of each State and the territories, and the Mayor of the District of Columbia.

The State P&A systems are authorized to monitor facility compliance with respect to the rights of individuals through activities that ensure the enforcement of the Constitution and federal and State statutes. The goal of the PAIMI Program is to expand the resources and capacity of State P&A systems to provide the following protection and advocacy services to individuals with mental illness and severe emotional impairment:

- To monitor all public and private residential care and treatment facilities and non medical community-based facilities for children and youth to ensure that they are not at risk for incidents involving the inappropriate use of seclusion and restraint, as required under the Children's Health Act of 2000.

- To investigate all incidents involving serious injuries and deaths related to incidents of seclusion and restraint used by staff in public and private residential care and treatment facilities and non medical community-based facilities for children and youth as required under the Children's Health Act of 2000.

- To protect and advocate for the rights of individuals with mental illness and severe emotional impairment while they reside in public or private residential care or treatment facilities.

- To provide services to individuals with mental illness living in the community, including their own homes, and to identify whenever possible the needs of unserved or under served populations of individuals with mental illness, such as, children, adolescents, women, the elderly, including ethnic and cultural minorities, who reside in rural and urban communities and residential facilities.

- To ensure that individuals with mental illness are provided appropriate support services when they are discharged from residential facilities into the community and that States address the community integration needs of these individuals as identified by the U.S. Supreme Court in the *Olmstead vs. L.C.* decision.

- To monitor State licensure and certification agencies responsible for establishing behavior modification training standards that address topics related to reducing incidents of seclusion and restraint, set forth in Section 3207 and 3208 of the Children's Health Act 2000.

The Children's Health Act of 2000 amended the PAIMI Act in two ways. First, the American Indian Consortium was added as the 57th grantee in order to protect the rights and to advocate on behalf of American Indians, provided the amounts appropriated for a fiscal year are at least $25,000,000. Second, the new legislation expanded the authority of the State P&A systems to provide services to individuals with mental illness living in the community, including their own homes, provided the funding level for a fiscal year is at least $30,000,000.

The Children's Health Act of 2000 also addressed the issues of unreported incidents of serious injuries and deaths that result from the inappropriate use of seclusion and restraint by poorly or untrained residential facility staff. Most States have no minimum certification or training requirements for residential facility staff, and this legislation now requires that States develop standards. State standards are to ensure that residential facility staff is appropriately trained in behavioral management techniques that focus on reducing the inappropriate use of seclusion and restraint in these facilities. In addition, facilities are required to report all deaths and serious injuries to the designated State agency and the State protection and advocacy system. The State P&A systems will then investigate these incidents.

The State P&A systems increased the number of clients served and the total number of complaints involving abuse, neglect, and rights violations that will be resolved in Fiscal Years 2000, 2001 and 2002 per the funding request:

PAIMI PROGRAM CLIENTS SERVED		
Fiscal Year (FY)	**Clients Served**	**Complaints Addressed**
2000 projected	18,000	29,500
2001 projected	21,700	33,300
2002 projected	21,700	33,300

Of the 26,474 abuse, neglect, and rights violation complaints addressed by the State P&A programs in FY 1999, the number of incidents involving abuse reported to the P&A systems decreased to 8,113 (FY 98: 8,667). The majority of these incidents involved failure to provide mental health treatment (28%), physical assault (14%), inappropriate or excessive restraint/seclusion (10%), failure to provide medical treatment (11%), and inappropriate or excessive medication (11%). In 1999, mental health facilities in 23 States and 1 territory reported 941 deaths to their State P&A systems. Thirty-nine (39) State P&A systems were able to investigate 458 facility deaths reported to them from all sources.

P&A systems efforts to investigate these incidents were affected by such factors as, inadequate information from the reporting facility, duration between the fatality and the notice to the P&A systems, a lack of facility cooperation, etc. State P&A systems conducted investigations of highly publicized deaths, often brought to their attention by the media (many States had no mandatory death reporting requirements to cover residential care and treatment facilities in effect) and issued findings which substantiated that residential facility staff either used excessive physical restraint or provided inadequate medical care.

In FY 1999, incidents involving individuals with mental illness and severe emotional disturbance placed in seclusion and restraint while in residential care and treatment facilities increased. News stories in the *Hartford Courant* and by *60 Minutes* focused national attention on the serious injuries and numerous fatalities that result when staff in residential care or treatment facilities are inadequately trained in behavioral management and de-escalation of emergency situations that often result in incidents of inappropriate use of seclusion and restraint. In 1999, the GAO and the DHHS OIG issued separate reports with similar findings that confirmed the inadequacy of State reporting systems to provide information on fatalities, serious injuries, use of seclusion and restraint, reports of abuse and neglect, and investigations of these incidents in residential facilities. FY 2000 data will be available in May 2001.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1997.....	$ 21,957,000	—
1998.....	21,957,000	—
1999.....	22,949,000	—
2000.....	24,903,000	—
2001.....	30,000,000	—

Rationale for the Budget Request . . . . . .

The FY 2002 President's budget proposes $30,000,000, the same level as the FY 2001 appropriation. These funds will serve approximately 21,700 individuals, address highlighted areas in the OIG and the GAO findings reports, implement the seclusion and restraint monitoring and investigation requirements authorized by the Children's Health Act of 2000, and the community expansion provisions to individuals with mental illness. The data elements used in the formula for FY 2001 and FY 2002 are: 1999 population estimates and average per capita income for 1997, 1998, 1999. The FY 2002 State allotment formula will be updated when the data is available later this year.

Center for Mental Health Services
Protection & Advocacy Program

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2001 Current Estimate	FY 2002 Estimate	Increase/ Decrease
Alabama	$321,081	$397,952	$397,952	$397,952	—
Alaska	321,081	355,300	355,300	355,300	—
Arizona	327,882	415,920	415,920	415,920	—
Arkansas	321,081	355,300	355,300	355,300	—
California	2,101,420	2,657,883	2,657,883	2,657,883	—
Colorado	321,081	355,300	355,300	355,300	—
Connecticut	321,081	355,300	355,300	355,300	—
Delaware	321,081	355,300	355,300	355,300	—
District of Columbia	321,081	355,300	355,300	355,300	—
Florida	986,069	1,244,417	1,244,417	1,244,417	—
Georgia	514,378	651,141	651,141	651,141	—
Hawaii	321,081	355,300	355,300	355,300	—
Idaho	321,081	355,300	355,300	355,300	—
Illinois	754,080	948,964	948,964	948,964	—
Indiana	403,269	506,667	506,667	506,667	—
Iowa	321,081	355,300	355,300	355,300	—
Kansas	321,081	355,300	355,300	355,300	—
Kentucky	321,081	359,050	359,050	359,050	—
Louisiana	321,081	397,585	397,585	397,585	—
Maine	321,081	355,300	355,300	355,300	—
Maryland	321,081	398,412	398,412	398,412	—
Massachusetts	365,398	458,830	458,830	458,830	—
Michigan	647,119	812,029	812,029	812,029	—
Minnesota	321,081	376,925	376,925	376,925	—
Mississippi	321,081	355,300	355,300	355,300	—
Missouri	369,009	463,170	463,170	463,170	—
Montana	321,081	355,300	355,300	355,300	—
Nebraska	321,081	355,300	355,300	355,300	—
Nevada	321,081	355,300	355,300	355,300	—
New Hampshire	321,081	355,300	355,300	355,300	—
New Jersey	474,955	599,980	599,980	599,980	—
New Mexico	321,081	355,300	355,300	355,300	—
New York	1,094,053	1,374,671	1,374,671	1,374,671	—
North Carolina	517,328	649,761	649,761	649,761	—
North Dakota	321,081	355,300	355,300	355,300	—

Center for Mental Health Services
Protection & Advocacy Program

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2001 Current Estimate	FY 2002 Estimate	Increase/ Decrease
Ohio	751,252	939,924	939,924	939,924	—
Oklahoma	321,081	355,300	355,300	355,300	—
Oregon	321,081	355,300	355,300	355,300	—
Pennsylvania	780,417	978,080	978,080	978,080	—
Rhode Island	321,081	355,300	355,300	355,300	—
South Carolina	321,081	355,300	355,300	355,300	—
South Dakota	321,081	355,300	355,300	355,300	—
Tennessee	375,617	472,735	472,735	472,735	—
Texas	1,338,941	1,688,060	1,688,060	1,688,060	—
Utah	321,081	355,300	355,300	355,300	—
Vermont	321,081	355,300	355,300	355,300	—
Virginia	437,372	551,296	551,296	551,296	—
Washington	364,649	459,268	459,268	459,268	—
West Virginia	321,081	355,300	355,300	355,300	—
Wisconsin	350,136	437,810	437,810	437,810	—
Wyoming	321,081	355,300	355,300	355,300	—
Puerto Rico	488,609	614,370	614,370	614,370	—
American Somoa	172,099	190,400	190,400	190,400	—
Guam	172,099	190,400	190,400	190,400	—
North Mariana Islands	172,099	190,400	190,400	190,400	—
Virgin Islands	172,099	190,400	190,400	190,400	—
American Indian Consor	—	190,400	190,400	190,400	
Total, States & Territori	24,404,941	29,400,000	29,400,000	29,400,000	—
Federal Set-Aside	498,059	600,000	600,000	600,000	—
TOTAL P&A	$24,903,000	$30,000,000	$30,000,000	$30,000,000	—

CENTER FOR MENTAL HEALTH SERVICES
4. Projects for Assistance in Transition from Homelessness (PATH)

Authorizing Legislation - Section 535 of the PHS Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
PATH	$30,883,000	$36,883,000	$36,855,000	+$5,972,000	$36,855,000	—

2002 Authorization $75,000,000

Purpose and Method of Operation .....

The Projects for Assistance in Transition for Homelessness (PATH) program was established in FY 1991 to provide community support services to individuals with serious mental illness who are homeless or at risk of becoming homeless. PATH is a formula grant program to States and U.S. Territories to provide (through local governmental entities or private nonprofit organizations) support services including outreach, screening and diagnostic treatment, community mental health services, alcohol and drug treatment, supervisory services in a residential setting; and referrals to other needed services.

The formula calculates State allotments based on the population living in urbanized areas. This population data is updated at the time of the census. The results of the 2000 census data will be available later this year to calculate final FY 2002 PATH allotments. The preliminary State allotments for FY 2002 shown in the State distribution table are based on the 1990 census data.

This program requires matching funds of $l to every $3 of federal funds. In FY 1998, State and local matching funds were almost double the required amount. PATH programs have been highly successful in targeting assistance to persons who have the most serious impairments.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1997.....	$20,000,000	--
1998.....	23,000,000	--
1999.....	26,000,000	--
2000.....	30,883,000	--
2001.....	36,855,000	--

Homeless persons with serious mental illnesses continue to crowd city streets and populate rural areas. Countless others remain out of sight. The requested resources will allow local PATH funded agencies to find, engage, and link hard to reach persons in need, with the services that will get them off the streets and into housing and treatment, regardless of the severity and duration of their illness.

As a result, PATH providers will fulfill the following PATH GPRA goals: (1) contact a total of 124,000 persons, targeting outreach and other services to those most in need; (2) maintain at the level of at least 35%, the percentage of persons contacted who become enrolled clients, even though these persons will be more difficult to engage, and; (3) maintain at the level of at least 84%, the percentage of participating agencies that offer outreach services.

Persons Contacted through PATH Outreach Efforts

FY 2000	109,000
FY 2001 est	124,000
FY 2002 est	124,000

The most recent program data indicate that 366 local agencies and/or counties utilized FY 1999 PATH funding. Adults in the age range 18-64 comprised 92 percent of the clients enrolled in services. Thirty two percent were African-American; 8 percent were of Hispanic origin. Clients receiving PATH-funded services have some of the most disabling mental disorders. For the States reporting diagnostic information, the most common diagnoses were schizophrenia and other psychotic disorders (43%), followed by affective disorders (36%) including severe depression and bipolar disorder. At least 58% had co-occurring serious mental illnesses and substance abuse disorders. At the time of first contact with providers, 50% of all clients had been homeless for more than 30 days. Despite the fact that they have multiple and complex needs and are very difficult to reach, 37% of the homeless individuals contacted through PATH funded outreach became enrolled.

A guidebook, *How To Be a Player in the Continuum of Care: Tools for the Mental Health Community*, has been prepared to help PATH-funded and other providers understand the HUD *Continuum of Care* planning process in their community and how they can participate.

Rationale for the Budget Request . . . . . .

The FY 2002 President's Budget proposes $36,855,000, the same level as the FY 2001 current estimate. This will allow States to maintain approximately the same level of services to the homeless population. CMHS will continue to work with States to implement evidence-based practices in local communities to reduce the level of homelessness among persons with mental illness.

Center for Mental Health Services
PATH Program

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2001 Current Estimate	FY 2002 Estimate	Increase or Decrease
Alabama	$300,000	$357,000	$357,000	$357,000	—
Alaska	300,000	300,000	300,000	300,000	—
Arizona	407,000	515,000	515,000	515,000	—
Arkansas	300,000	300,000	300,000	300,000	—
California	3,900,000	4,938,000	4,938,000	4,938,000	—
Colorado	364,000	461,000	461,000	461,000	—
Connecticut	376,000	476,000	476,000	476,000	—
Delaware	300,000	300,000	300,000	300,000	—
District of Columbia	300,000	300,000	300,000	300,000	—
Florida	1,559,000	1,973,000	1,973,000	1,973,000	—
Georgia	499,000	632,000	632,000	632,000	—
Hawaii	300,000	300,000	300,000	300,000	—
Idaho	300,000	300,000	300,000	300,000	—
Illinois	1,298,000	1,644,000	1,644,000	1,644,000	—
Indiana	412,000	522,000	522,000	522,000	—
Iowa	300,000	300,000	300,000	300,000	—
Kansas	300,000	300,000	300,000	300,000	—
Kentucky	300,000	300,000	300,000	300,000	—
Louisiana	341,000	432,000	432,000	432,000	—
Maine	300,000	300,000	300,000	300,000	—
Maryland	548,000	694,000	694,000	694,000	—
Massachusetts	724,000	917,000	917,000	917,000	—
Michigan	890,000	1,127,000	1,127,000	1,127,000	—
Minnesota	363,000	460,000	460,000	460,000	—
Mississippi	300,000	300,000	300,000	300,000	—
Missouri	426,000	540,000	540,000	540,000	—
Montana	300,000	300,000	300,000	300,000	—
Nebraska	300,000	300,000	300,000	300,000	—
Nevada	300,000	300,000	300,000	300,000	—
New Hampshire	300,000	300,000	300,000	300,000	—
New Jersey	1,015,000	1,285,000	1,285,000	1,285,000	—
New Mexico	300,000	300,000	300,000	300,000	—
New York	2,162,000	2,737,000	2,737,000	2,737,000	—
North Carolina	385,000	487,000	487,000	487,000	—
North Dakota	300,000	300,000	300,000	300,000	—

PATH Program

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2001 Current Estimate	FY 2002 Estimate	Increase or Decrease
Ohio	1,019,000	1,291,000	1,291,000	1,291,000	—
Oklahoma	300,000	300,000	300,000	300,000	—
Oregon	300,000	300,000	300,000	300,000	—
Pennsylvania	1,104,000	1,397,000	1,397,000	1,397,000	—
Rhode Island	300,000	300,000	300,000	300,000	—
South Carolina	300,000	300,000	300,000	300,000	—
South Dakota	300,000	300,000	300,000	300,000	—
Tennessee	340,000	430,000	430,000	430,000	—
Texas	1,742,000	2,205,000	2,205,000	2,205,000	—
Utah	300,000	300,000	300,000	300,000	—
Vermont	300,000	300,000	300,000	300,000	—
Virginia	586,000	743,000	743,000	743,000	—
Washington	492,000	623,000	623,000	623,000	—
West Virginia	300,000	300,000	300,000	300,000	—
Wisconsin	377,000	478,000	478,000	478,000	—
Wyoming	300,000	300,000	300,000	300,000	—
Puerto Rico	325,000	412,000	412,000	412,000	—
American Somoa	50,000	50,000	50,000	50,000	--
Guam	50,000	50,000	50,000	50,000	--
North Mariana Islands	50,000	50,000	50,000	50,000	--
Virgin Islands	50,000	50,000	50,000	50,000	--
Total, States & Territories	29,954,000	35,776,000	35,776,000	35,776,000	—
Federal Set-Aside	929,000	1,107,000	1,079,000	1,079,000	—
TOTAL, PATH	$30,883,000	$36,883,000	$36,855,000	$36,855,000	—

CENTER FOR MENTAL HEALTH SERVICES
5. Community Mental Health Services Block Grant

Authorizing Legislation - Section 1920 of the PHS Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
PRNS	$356,000,000	$420,000,000	$420,000,000	+$64,000,000	$420,000,000	---

2002 Authorization ..... Such Sums as Necessary

Purpose and Method of Operation .....

The goal of the Community Mental Health Services Block Grant (MHBG) is to assist the 59 eligible and participating States and Territories in providing the appropriate level of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) within their communities as an alternative to the costly and restrictive inpatient hospital care. Individuals receive enhanced community services through a balanced system of treatment and supports to live more fulfilling and productive lives.

CMHS is guided by the underlying values of community-based treatment and the specific criteria that must be addressed in the planning and development of community-based systems of care. CMHS has provided a consistent national framework and focus to assist States as they fulfill the expectation that the entire infrastructure of their service delivery system, and particularly the use of State psychiatric hospitals, should be in a continual evolution and realignment until it becomes predominantly community-based.

While most of the funds are allocated to the States to assist in the development of community-based care systems for the more than 2 million persons they serve, five percent is available to CMHS to support technical assistance, data collection, and evaluation activities that assist States in their work. A number of such activities are funded, including state-of-the-art technical assistance provided by the National Technical Assistance Center for State Mental Health Planning. In a recent review of the States' spending of MHBG funds, The National Association of State Mental Health Program Directors (NASMHPD) concluded that "in general, States are using the block grant exactly as intended; that is, as a flexible pool of resources to support a broad range of activities specific to the needs of each State. This flexibility provides States with an incentive to develop new community-based services and additional resources to support an expansion of existing services. Although the block grant represents only a small proportion of the overall State mental health agency budget in most States, it is apparent that these dollars support critical and innovative services."

The MHBG buttresses the traditional responsibility of State systems, serving as the mental health service safety net and catastrophic insurer for those with the most severe problems and the fewest

resources. The MHBG primarily serves those individuals with no mental health coverage and those who exhaust limited mental health benefits in their health insurance.

The MHBG has met with success in helping to redesign the infrastructure of the States' mental health delivery systems and moving clinical care to the community. From 1970-1994, the number of State psychiatric hospital beds decreased by over 400%. While downsizing of facilities is important in moving the locus of care, it is not as significant as actual infrastructure changes such as the closure of hospitals and the movement to the use of community facilities. From 1990-1996 a total of 34 State psychiatric hospitals were closed. It is anticipated that this trend will continue.

While goals have been achieved regarding the locus of care, great numbers of Americans with SMI and SED continue to go untreated or if they do receive treatment, it is inadequate for their needs. For example, it has been documented that of the estimated 10.8 million Americans who have 12-month serious mental illness, 6.6 million did not obtain "stable treatment" during the past 12 months (Kessler, 1999). By 1999, CMHS had documented an estimated 90% of all Americans with a psychiatric diagnosis as not receiving any form of specialty mental health care, and two-thirds of persons with a SMI had not received targeted mental health services.

CMHS is striving to identify and collect quantitative data that would demonstrate that the State programs that the MHBG supports are efficient and effective. State data now available was developed individually by the States, based on their own unique needs and definitions, resulting in great variation in their data reporting as well as their data infrastructure system. This lack of uniform data was the impetus for the development of the three year 16-State Pilot Indicator Grant Project and other efforts to move the States to a uniform national data system.

In an effort to increase State flexibility and to develop an accountability system based on performance, SAMHSA has been working with the States over the past several years to recreate the block grant programs into performance partnerships. Public Law 106-310 enacted on October 17, 2000 requires the Secretary to submit to Congress by October 17, 2002 a plan which will outline among other things the flexibility that States will receive under the new partnership and the performance measures that will be used to hold States accountable for their use of Federal funds.

Thanks to the collaborative effort between SAMHSA and the States, we will meet this requirement. Once this is accomplished, SAMHSA will be able to tell Congress what changes have occurred in access to care, the effectiveness of that care, and how successful the services have been in addressing the needs of vulnerable populations in each of the States and territories. The intent of this program is continued quality improvement. The information gained will help both the State and the Federal government better identify where improvement is needed and the services needed to make those improvements.

A 16-State Pilot is aimed at developing a viable framework for uniform reporting of performance in the MHBG. The Pilot has passed year two and currently has data available for ambulatory programs, as well as consumer feedback on treatment for access, appropriateness of care and outcomes. Additional Pilot data will be available in early FY 2002. In addition to the data collection efforts of the 16-State Pilot Project, the MHBG program, in collaboration with the States has developed a

framework for a uniform data reporting system that identifies and defines a number of common data elements on which the States will be asked to report beginning in FY 2002.

The 16 State Project has made strides in the collection of comparable data across the 16 participating States. A very basic piece of data that heretofore has been missing is the utilization rates of the public mental health system. These rates address the fundamental issue of the degree to which people in different States make use of the public mental health care systems. During its first year, the 16 State project focused on State mental hospital utilization rates. Two quantitative measures were used including utilization rates comparing the number of people hospitalized during fiscal year 1998 to the total population of each State. Of the 14 States reporting data each year, nine States reported increases in the per capita utilization while five reported decreases. When the data for those States is aggregated, there is an overall decline of 8% in the hospitalization rate of the State psychiatric hospitals. As indicated previously, this decline is consistent with the Mental Health Block Grant goal of moving the locus of care from the hospital to the community.

Another hospital measure is the readmission rate of persons with serious mental illness to State psychiatric hospitals. The 16 State project is collecting data on the readmission rates to hospitals within 30 and 180 days of discharge. Eleven of the States are currently able to report this data on a uniform basis. In addition to assisting in evaluating whether the locus of care is moving to the community, this measure can also assist in identifying inappropriate re-admissions and ensuring that systems are providing services that will allow consumers to return to the community with the necessary skills and resources to maintain themselves there on a permanent basis.

While CMHS has made significant progress in pioneering the collection of uniform State mental health data, considerably more work is necessary. For example, unduplicated counts need to be developed through a focus on building data and other infrastructures that will combine the State hospital system with the community-based system.

As States have grappled with the difficulties associated with tremendous change in their system infrastructures and the corresponding shifts of resources, much work still needs to be done to ensure that States develop a comprehensive community-based system of care for adults with SMI and children with SED. States continue to be unable to treat all persons in need of care and are unable to conduct aggressive outreach activities despite considerable evidence demonstrating that many persons needing care are not receiving it. Further, there are serious gaps in service for those who are in treatment.

For community-based systems to work, an array of support services must be in place to help the person function in the community. Almost all States are now challenged in filling gaps around the need for: residential and therapeutic housing; job and work opportunities for the targeted population; and other support services that are not reimbursed or funded because they are not traditionally considered medically necessary. These service gaps contribute to homelessness, damaged interpersonal and family relationships, lost productivity and substance abuse, absenteeism from work and school, increased incidences of suicides, criminal involvement, and psychiatric hospitalizations.

The severity of gaps in the community based systems of care for persons with SMI was brought to the forefront in 1999 with the Supreme Court decision in Olmstead v. L.C., 119 S. Ct. 2176 (1999).

In this ruling the Supreme Court interpreted Title II of the Americans with Disabilities Act and determined that the unnecessary segregation of persons in State psychiatric facilities and other long term care programs constitutes discrimination. Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonable determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services.

Olmstead seriously challenges States to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure persons with disabilities are served in the most integrated setting appropriate. Olmstead obliges States to administer their programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

In order to assist States to expand the community-based supports, CMHS has initiated National and Statewide Coalitions to Promote Community-Based Care. The National Coalition is bringing together Federal agencies with traditional and non-traditional stakeholder organization to leverage resources, policies, programs, and practices to promote the transition of persons with mental illnesses into community-based systems of care. Financial assistance is being provided to State mental health authorities to enhance collective action at the State level as well in building Statewide Coalitions to implement the Olmstead decision. The National Coalition is acting as a resource to assist the local coalitions in developing linkages between systems servicing individuals with mental illnesses to receive treatment in their communities.

The President's New Freedom initiative recognizes that the Olmstead decision has yet to be fully implemented. This initiative recognizes that community-based care is critically important to promoting maximum independence and that integrating individuals with disabilities into community life is necessary. Supporting the most integrated community-based settings for individuals with disabilities has been a basic tenet of the MHBG since it was created in1981.

The number of clients served is based on an estimate derived by using the average claimant costs for ambulatory care of $1,718 per client in FY 2001 and $1,754 in FY 2002.

FY 2000	FY 2001	FY 2002
197,000	232,000	227,000

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1997	$275,420,000	11
1998	275,420,000	11
1999	288,816,000	11
2000	356,000,000	17
2001	420,000,000	17

Rationale for the Budget Request . . . . . .

The FY 2002 President's budget proposes $420,000,000, the same level as the FY 2001 current estimate. Each State and Territory will continue to receive an allocation based on the formula to improve community-based mental health services and to support national data collection and technical assistance activities.

The Mental Health State Block Grant allotment table which follow this section shows that, while the budget request remains the same in total as in FY 2001, individual State allotments vary. For the most part these are relatively small fluctuations which result from the required annual update of two of the three components of the Block Grant formula, the population at risk of a mental health or substance abuse problem, and a factor reflecting States' relative capacities to support mental health services. SAMHSA's recent reauthorization included a "hold harmless" provision which mandates that no Mental Health State allotment will be less than that State received in 1998. None of the State allotments fall below the amount received by the State in FY 1998, however, this hold harmless provision does not prevent reductions which will be required in 33 State allocations in FY 2002.

Funds will be used to continue developing strategies that increase access to care for populations traditionally underserved and untreated, such as women, children, people in rural areas, ethnic minorities, and the elderly. In addition, these funds will be used to furnish States with the technical assistance they need to bolster and support their systems of community-based mental health care. States have consistently requested such technical assistance in various areas, such as:

- developing management information systems;
- implementing systems of managed care;
- targeting individuals with co-occurring substance abuse disorders and mental illness for services;
- developing mental health courts;
- strengthening State mental health planning and advisory councils;
- transition planning for adults and adolescents;
- providing outreach to youth in the juvenile justice system;
- expansion of services to the elderly;
- collecting data; and
- providing services in a culturally competent manner.

Data Sources Used to Calculate the FY 2002 Allotments

- **Total Personal Income** (TPI) - Bureau of Economic Analysis, Department of Commerce; Regional Accounts Data, State Personal Income, 1997-1999, downloaded from BEA web site; source data filename: SA1_5899.PRN, release date 9/12/2000. BEA web site is http://www.bea.doc.gov.

- **Resident Population** - Bureau of the Census, Department of Commerce; Population Estimates for the U.S. and States by Single Year of Age and Sex: July 1, 1999 downloaded from Census

web site; source data text file name: ST-99-10.txt, Internet release date 3/9/2000. Census web site is http://www.census.gov/population/www/estimates/st-99-10.html.

- **Total Taxable Resources** (TTR) - Office of Economic Policy, Department of the Treasury; Total Taxable Resources, 1996-1998 provided directly to OAS via e-mail; source data filename: 2000EST.xls, release date 9/29/2000. Data also available on the Treasury web site http://www.treas.gov/ttr.

- **Population data for the territories** based on 1990 Census Data except Micronesia and the Marshall Islands - Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were not included in the 1990 census.

- A **Cost of Services Index Factor**, updated for FY 2001 under a three-year periodic update, includes the following:

  Fair Market Rents for the Section 8 Housing Assistance Payments Program — Fiscal Year 2000, downloaded from the HUD web site http://www.huduser.org/datasets/fmr: (a) fmr2000f.dbf, dbase file, released 10/1/99, created 9/23/99 (dbase is the only machine-readable format in which the raw data are offered); (b) fmr2000f.txt, text file, FMR data record layout and file description, released 10/1/99, created 9/27/99; (c) 2000f_pre.doc, Word file, Federal Register preamble of the FY2000 FMR calculations, released 10/1/99; and (d) fmrover.wp, WordPerfect version of the Federal Register preamble.

  Metropolitan Areas, 1999, released by the Office of Management and Budget 6/30/99, filename MSA99.pdf; used by HUD in development of FMR rates. Changes in Metropolitan Areas as Defined by the Office of Management and Budget Since June 30, 1993, filename MAUPDATE.txt, released 6/30/99, Bureau of the Census.

  1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1996 hourly hospital wages developed from data collected for the establishment of FY 2000 HCFA Hospital Inpatient Prospective Payment System Wage Rates, collected from the HCFA Internet web site http://www.hcfa.gov/stats/pufiles, publicly available on August 17, 1999. Both executable and zip versions of the data file WAGEDATA.F96 were available on the web site as 1.2 MB self-extracting files which decompressed to a 5 MB fixed length (i.e. "flat") ASCII file consisting of 5,038 records (one record for each unique facility reporting to HCFA); the executable version was downloaded and decompressed. Also downloaded was the file for the data record layout (WDF2000), which was available in several formats.

Guidance was also provided by HCFA regarding relevant changes which occurred in reporting format between the FY 1997 and FY 2000 hospital wage data releases.

Substance Abuse and Mental Health Services Administration
Community Mental Health Services Block Grant

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate	Increase/ Decrease
Alabama	$5,247,803	$6,220,723	$6,267,851	+$47,128
Alaska	715,829	762,905	750,176	-12,729
Arizona	5,734,460	6,657,364	6,597,321	-60,043
Arkansas	2,985,186	3,607,391	3,592,835	-14,556
California	46,170,018	54,652,725	55,522,367	+869,642
Colorado	4,313,213	5,094,169	5,039,334	-54,835
Connecticut	3,994,050	4,573,611	4,488,004	-85,607
Delaware	801,763	943,578	969,680	+26,102
District Of Columbia	720,407	830,293	847,055	+16,762
Florida	20,004,734	24,194,151	24,216,574	+22,423
Georgia	9,664,928	11,915,992	11,958,188	+42,196
Hawaii	1,494,983	1,682,488	1,683,289	+801
Idaho	1,378,861	1,682,538	1,734,655	+52,117
Illinois	13,451,179	16,248,971	16,243,799	-5,172
Indiana	7,019,264	8,220,321	8,183,208	-37,113
Iowa	3,071,528	3,587,827	3,558,952	-28,875
Kansas	2,767,226	3,273,481	3,279,549	+6,068
Kentucky	4,836,151	5,678,236	5,727,709	+49,473
Louisiana	5,289,531	6,102,402	6,044,544	-57,858
Maine	1,500,026	1,762,274	1,777,669	+15,395
Maryland	6,951,146	8,384,454	8,295,182	-89,272
Massachusetts	7,488,782	8,443,383	8,390,585	-52,798
Michigan	11,633,936	13,278,250	13,199,457	-78,793
Minnesota	4,895,304	5,828,519	5,720,177	-108,342
Mississippi	3,277,046	3,864,148	3,878,044	+13,896
Missouri	5,864,082	6,887,730	6,885,965	-1,765
Montana	1,028,398	1,213,588	1,212,982	-606
Nebraska	1,727,251	2,011,272	1,980,778	-30,494
Nevada	2,185,130	2,756,629	2,767,924	+11,295
New Hampshire	1,279,932	1,448,762	1,458,966	+10,204
New Jersey	10,302,377	12,112,785	12,047,602	-65,183
New Mexico	1,872,498	2,181,353	2,172,430	-8,923
New York	23,765,183	28,257,608	28,193,000	-64,608
North Carolina	8,483,792	9,950,039	9,932,418	-17,621
North Dakota	735,029	853,844	823,218	-30,626

Substance Abuse and Mental Health Services Administration
Community Mental Health Services Block Grant

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate	Increase/ Decrease
Ohio	12,845,283	15,027,530	14,988,647	-38,883
Oklahoma	3,896,203	4,596,551	4,546,634	-49,917
Oregon	3,741,020	4,272,535	4,203,605	-68,930
Pennsylvania	14,411,620	16,433,134	16,331,987	-101,147
Rhode Island	1,284,233	1,456,182	1,419,841	-36,341
South Carolina	4,493,573	5,411,135	5,479,276	+68,141
South Dakota	779,348	899,986	882,765	-17,221
Tennessee	6,404,231	7,945,336	7,970,827	+25,491
Texas	25,320,364	29,347,859	29,454,436	+106,577
Utah	2,205,056	2,667,382	2,655,278	-12,104
Vermont	688,760	816,103	821,987	+5,884
Virginia	8,918,079	10,661,315	10,624,325	-36,990
Washington	7,139,921	8,527,239	8,442,768	-84,471
West Virginia	2,246,329	2,630,833	2,616,936	-13,897
Wisconsin	5,692,136	6,683,935	6,662,426	-21,509
Wyoming	409,908	474,141	471,778	-2,363
State Sub-total	**333,127,090**	**393,015,000**	**393,015,000**	0
American Samoa	58,768	69,438	69,438	(0)
Guam	167,300	197,675	197,675	0
Northern Marianas	54,461	64,349	64,349	0
Puerto Rico	4,425,283	5,228,758	5,228,758	0
Palau	50,000	50,000	50,000	0
Marshall Islands	56,208	66,413	66,413	0
Micronesia	133,062	157,222	157,222	(0)
Virgin Islands	127,918	151,144	151,144	(0)
Territory Sub-total	**5,073,000**	**5,985,000**	**5,985,000**	0
SAMHSA Set-Aside	**17,799,910**	**21,000,000**	**21,000,000**	0
GRAND TOTAL	**$356,000,000**	**$420,000,000**	**$420,000,000**	0

SUBSTANCE ABUSE PREVENTION
Overview

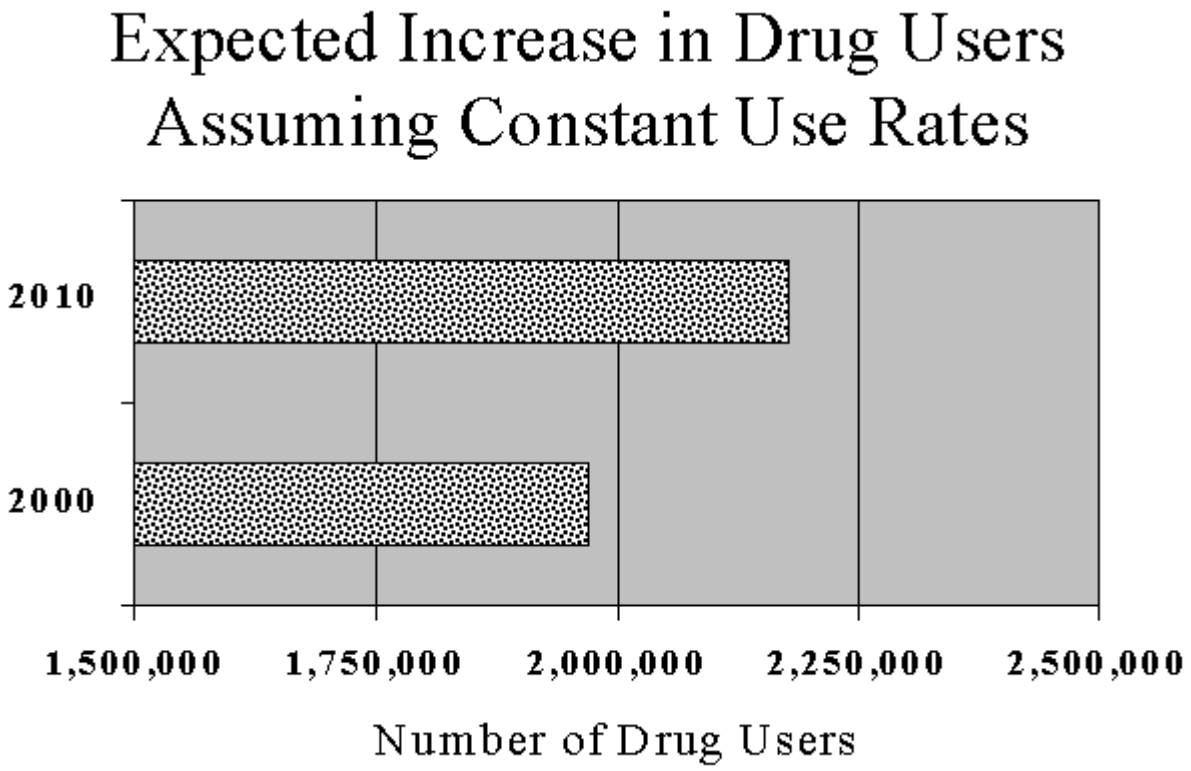
	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
PRNS	$146,705,000	$175,145,000	$175,013,000	+$28,308,000	$175,013,000	---

SAMHSA's Center for Substance Abuse Prevention (CSAP) is the sole Federal organization with responsibility for improving accessibility and quality of substance abuse prevention services. The Center provides national leadership in the development of policies, programs and services to prevent the onset of illegal drug use, underage alcohol and tobacco use, and to reduce the negative consequences of using substances.

Substance abuse is a serious public health problem. In 1995, the Association of American Physicians reported that substance abuse costs taxpayers over $400 billion each year in direct medical costs, loss of productivity and earnings, and social costs such as law enforcement, social welfare, and accidents. In January 2001, the National Center on Addiction and Substance Abuse (CASA) at Columbia University reported States spent $81.3 billion (13% of total State spending) to deal with substance abuse and addiction, including their impact on health, social services, education, and the criminal justice system. Speaking to the need for a federal role in prevention, the study pointed out that only four cents out of every dollar spent by States on substance abuse and addiction was used to prevent and treat it. One effective method for closing the treatment gap is to prevent Americans from becoming drug dependent.

The 1999 National Household Survey on Drug Abuse (NHSDA) reports 14.8 million Americans were current users of illicit drugs in 1999. The report also shows important differences in usage trends among age cohorts. Significant declines are evident for youth age 12 to 17 (21% decrease in illicit drug use since 1997). This bodes well for reducing the treatment gap as this cohort matures. However, substantial *increases* have occurred for 18- to 25-year olds (28% increase since 1997). These young adults are the same individuals who contributed to the high drug rates of the early to mid-1990s, and are now continuing their high rates of use.

These findings signify the need not only for increased attention to older adolescents and young adults, but also for continued prevention efforts for youth and people of all ages facing critical life transitions. Among very young children, recent research has demonstrated the importance of early intervention in physical, social, and cognitive development. The elderly, individuals age 65 and older, account for more than half of all reported cases of adverse prescription medication reactions leading to hospitalization. This is even more alarming given the aging of the baby boom generation. Thus, CSAP is now expanding its efforts to determine what works for which populations and under what conditions across the life span.



Prevention efforts will become even more essential in the next several years, as the children of the baby boom generation reach their most vulnerable age for substance abuse. The 15-20 age group, which exhibits the highest levels of substance abuse, will grow by about 11% or 2.3 million youth in the next ten years. Even if rates of youth drug use remain constant at 9% , we can expect many more substance abusers and related health and social problems due simply to this projected growth in the youth population. At current use rates, this growth will also create about 207,000 more regular illicit drug users.

Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
Budget Mechanism Table
(Dollars in Thousands)

	FY 2000 Actual		FY 2001 Appropriation		FY 2002 Estimate	
	No.	Amount	No.	Amount	No.	Amount
Programs of Regional and National Significance:						
Grants/Cooperative Agreements:						
Continuations	252	$109,826	120	$61,570	163	$102,434
New/Competing	5	14,090	148	73,516	83	32,153
Subtotal	257	$123,916	268	$135,086	246	$134,587
Contracts:						
Continuations	17	$17,720	18	$18,512	30	$28,300
New/Competing	7	2,015	18	18,417	6	9,050
Subtotal	24	$19,735	36	$36,929	36	$37,350
Technical Assistance	4	2,434	4	2,093	4	2,171
Review Cost	---	620	---	905	---	905
Subtotal	28	$22,789	40	$39,927	40	$40,426
Total, PRNS	***285***	***$146,705***	***308***	***$175,013***	***286***	***$175,013***

Programs of Regional and National Significance
Substance Abuse Prevention

Authorizing Legislation - Sections 516, 517, 519A, 519C, and 519D of the Public Health Service Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
Best Practices	$47,505,000	$58,745,000	$58,613,000	+$11,108,000	$58,203,000	-$410,000
TCE	77,000,000	96,900,000	96,900,000	+19,900,000	98,610,000	+1,710,000
High Risk Youth	7,000,000	7,000,000	7,000,000	---	7,000,000	—
Strength Families	10,500,000	1,300,000	1,300,000	-9,200,000	—	-1,300,000
FAS/FAE	4,700,000	11,200,000	11,200,000	+6,500,000	11,200,000	—
Total	$146,705,000	$175,145,000	$175,013,000	+28,308,000	$175,013,000	---

2002 Authorization ..... Such Sums as Necessary

Purpose and Method of Operations .....

Through the Programs of Regional and National Significance (PRNS) activity, SAMHSA's Center for Substance Abuse Prevention (CSAP) supports an integrated systems approach to preventing substance use and abuse in this country. This approach promotes and enhances SAMHSA activities to achieve the following goals:

- Assure services availability
- Meet unmet and emerging needs
- Bridge the gap between knowledge and practice

The major components of this approach are to:

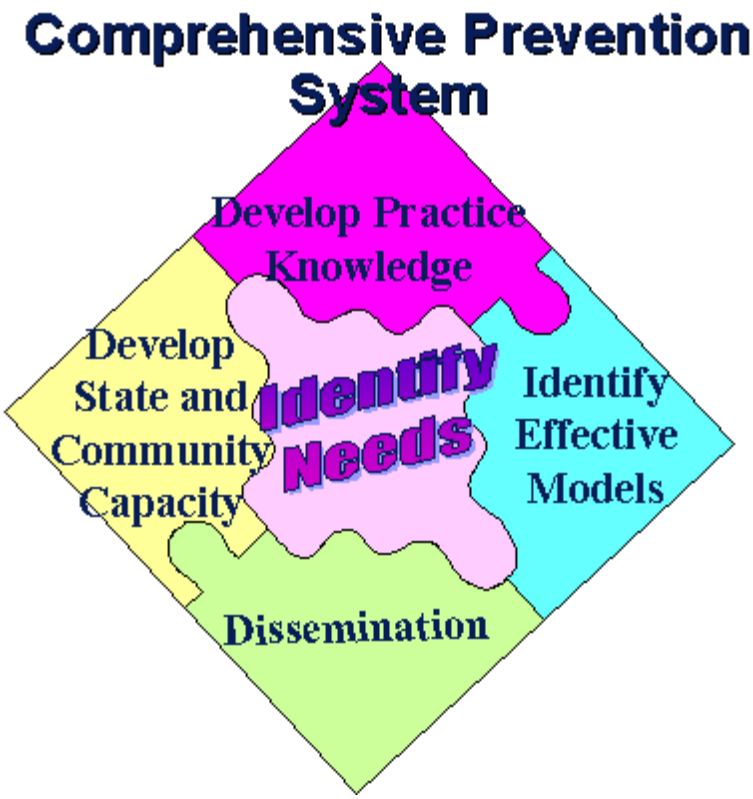
- support the development of new practice knowledge on substance abuse prevention,
- identify proven effective models,
- disseminate science-based intervention information,
- build State and community capacity for wide-spread implementation of proven effective substance abuse prevention programs, and
- address new needs in the prevention system.

Major distribution of CSAP PRNS program funds for substance abuse prevention include:

Programs of Regional & National Significance
Program Distribution of Funds
(dollars in thousands)

	FY 2000	FY 2001	FY 2002
Substance Abuse Prevention:			
Youth Prevention Programs	$44,205	$49,413	$50,713
Workplace Prevention	3,300	4,400	4,400
HIV/AIDS	8,500	32,100	32,100
State Incentive Grants	60,400	60,600	60,600
Centers for the Application of Prevention Technologies	8,100	9,000	9,000
High Risk Youth	7,000	7,000	7,000
Strengthening Families	10,500	1,300	—*
Fetal Alcohol Syndrome/Fetal Alcohol Effects	4,700	11,200	11,200
Total	$146,705	$175,013	$175,013

* Strengthening Families models will be incorporated in High Risk Youth programs in FY 2002. Funds are re-allocated to Youth Prevention Programs.



CSAP's comprehensive prevention system is an integrated approach designed to get the right tools into the hands of States and communities. The goal is to bring effective substance abuse prevention practices to every community to help ensure reductions in substance abuse. In support of this goal, CSAP actively collaborates with other Federal, State, public and private organizations.

A. Developing and Applying Best Practices:

Develop Practice Knowledge

Building on the SAMHSA Goal to bridge the gap between knowledge and practice, CSAP supports programs which expand, adapt and refine for practice new knowledge for the prevention of substance abuse - this includes prevention knowledge outside of the clinical/research setting. Knowledge Development (KD) programs identify, implement, and field test prevention programs to determine effectiveness with diverse populations in real life environments. Some of the problems addressed by KD programs include the emerging increases in "ecstasy" use among students, steroid use among younger males, and the persistent problem of underage alcohol use. SAMHSA will identify those strategies that are effective in preventing the use of these harmful substances. Prevention efforts must be tailored to particular drugs and audiences to effectively address young people's beliefs and attitudes specific to each drug. CSAP's grantee programs are rigorously evaluated to determine effectiveness of research-based prevention programs when implemented by community providers. Thorough cross-site evaluations, coordinated core measures, data pooling, and cross-site analysis are used, thus increasing the ability to identify what works, for whom, and under what circumstances.

The FY 2002 budget request continues support for High Risk Youth grants focusing on youth ages 9 - 15 and their families. These High Risk Youth projects support a diverse array of mentoring and family strengthening models, including youth education on substance abuse, life management skills, conflict resolution, tutoring, family communication, and others. GPRA data from the Predictor Variable Studies illustrate that substance use substantially decreases (e.g., tobacco use reduction from 2.6 to 0.5% vs. 1.1 to 2.3% increase in the control group) when effective programs target these and other identified precursors.

Analysis of prior High Risk Youth programs at 48 sites affecting 10,000 youth concluded that high risk youth who were more connected to positive social environments, such as family and school, used substances less than those who lacked such connections. Another key finding was that prevention program results differed for boys and girls: substance use outcomes were more positive for boys at program's end, but positive outcomes emerged later and lasted longer for girls. Overall, youth who take part in prevention programs have statistically significant lower levels of alcohol and marijuana use than those in comparison groups. Building upon experience with the Family Strengthening program, CSAP decided to incorporate the concept into the High Risk Youth program. In FY 2002, CSAP will expand mentoring and family strengthening programs to serve a greater number of persons, in multiple locations and diverse settings. Outcomes expected are reductions in substance use, and improved family and school attitudes and behaviors.

The FY 2002 request also supports continuation of the Community Initiated Interventions program. This program provides grants to communities to implement prevention programs focused on priority issues and specific populations. Communities select a prevention strategy according to their needs and then test, adapt, refine and/or replicate research-based interventions among different populations in disparate community settings. This program assures effective prevention strategies are relevant and appropriate to communities, by adapting, disseminating, and applying programs that meet a community's unique needs. This program will focus on several emerging issues in substance abuse prevention: fetal alcohol syndrome/alcohol related birth defects; gender-specific programming; children of substance abusing parents; methamphetamine, ecstacy, or club drugs; underage or binge

drinking; workplace substance abuse focused on young adults; and drug misuse among the elderly population. SAMHSA/CSAP will build on knowledge already gained through existing programs, such as the Workplace Managed Care Program which showed prevention strategies effective in reducing the incidence and prevalence of substance abuse in the workplace and managed care settings. For example, while final results are not yet available, preliminary GPRA data show an increase of 44.7% of parents with a negative attitude toward substance use; a 40.9% increase in perceived risk among children aged 9-14 and a similar increase of 40.5% among children aged 6-8.

CSAP also will continue to support prevention interventions in early childhood through the Strengthening Early Interventions by Integrating Behavioral Health Services program, an extension of its successful Starting Early/Starting Smart (SESS) program. The SESS program is a unique public/private collaboration to test the effectiveness of integrated mental health and substance abuse prevention and treatment services for children up to seven years old and their parents and caregivers. The accomplishments, systems implemented, and lessons learned from the SESS program will be especially useful in supporting this type of innovative approach. For example, SESS has reached about 3000 children and families with an astounding 78% retention rate over the last three years. Early results show positive trends in physical health, behavior, and social and emotional functioning, as well as improved collaboration across private and public agencies. Overall performance on SESS GPRA measures shows better physical health, behavioral health, and cognitive development for the intervention groups than for the comparison groups.

Expected outcomes of this new effort include: improved delivery of behavioral health services; improved quality of behavioral health services; the identification of early childhood models for effective preventive services in an integrated system.

Identify Best Practices

Another component of CSAP's KD efforts addresses the significant gap in assistance to local communities to implement scientifically-defensible, effective substance abuse prevention programs. CSAP's objectives are to identify and replicate model prevention programs, and to significantly increase the number of communities implementing science-based prevention programs. Scientifically-defensible programs are well-implemented, well-evaluated and produce consistent positive results. Such programs are often adapted to meet the specific needs of the target population and the local social and cultural environment.

"Rocky" Anderson, Mayor of Salt Lake City in his keynote address at a conference entitled "Working Together for Better Outcomes: New Strategies for Dealing with Drug and Alcohol Abuse and Drug-Related Crime" in December 2000, recognized the value of CSAP's efforts to identify best practices by announcing the city decision to provide financial support for an NREPP model program in the Salt Lake City school district.

The FY 2002 budget continues support for the National Registry of Effective Prevention Programs (NREPP) which identifies model prevention programs. The Registry begins with an expert consensus review of source documents solicited from the prevention field. The areas for search include programs identified by other Federal agencies (e.g., NIDA, NIAAA), State and local governments,

universities and foundations. Upon identification, programs are reviewed for both scientific credibility as well as demonstrated effectiveness. In FY 2001 SAMHSA will have identified 20 new model drug abuse prevention programs. The twenty new programs complement 19 programs previously identified in FY 2000. These models represent considerable diversity as to program outcomes (tobacco, alcohol, multi-drug prevention, steroid prevention, violence prevention, risk and protective factor modifications) and program strategies (individually-focused and community/environmentally-focused interventions).

39 Models Have Been Identified to Date (April 2001)
Model Example: Child Development Project

- Reduced new cigarette smoking by 75%
- Reduced alcohol use by 54%, heavy drinking by 73%
- Reduced marijuana use by 71% and weekly/daily use by 83%

Dissemination

CSAP's Knowledge Application (KA) efforts include broader dissemination and adoption of effective substance abuse prevention programs and strategies. What works in preventing substance abuse is well documented. The successful key to this piece of the system is disseminating information, materials, and tools needed by the public and prevention practitioners to expand the use of science-based information and best practice models in the Nation's communities, consistent with SAMHSA's goal to bridge the gap between knowledge and practice.

CSAP developed a dissemination website for the model prevention programs where, with a simple click, communities can access practical, detailed information on models identified through the Registry. The website provides communities with the tools necessary to implement science based programs. Through the website, communities can access staffing and training, program costs, planning and facilities, participant recruitment, and evaluation information - all to assist in program implementation. This site was launched in January 2000 and over the past year averaged more than 25,000 hits per month (www.samhsa.gov/csap/modelprograms/).

To take advantage of technology and rapid dissemination, CSAP has begun to develop the Decision Support System (DSS), building from the model program website. The DSS will be highly interactive, web-based software providing free technical assistance, training and other resources in all aspects of prevention. The DSS provides prevention practitioners at all levels with immediate, direct access to a wide range of scientifically sound prevention resources. The system provides access to a number of prevention databases and "how to" prevention content areas, thus greatly expanding the knowledge base of prevention professionals at the federal, State, and local levels. For example, the system enables the user to conduct state-of-the-science needs assessments, select scientifically sound best program practices to meet local needs, monitor service delivery and fidelity of program implementations, access the best measures for targeted outcome indicators, and analyze and report on program effects and outcomes using core measures. End-users can adapt the DSS to their respective technological skill levels, learning preferences, and the capacities of their specific equipment.

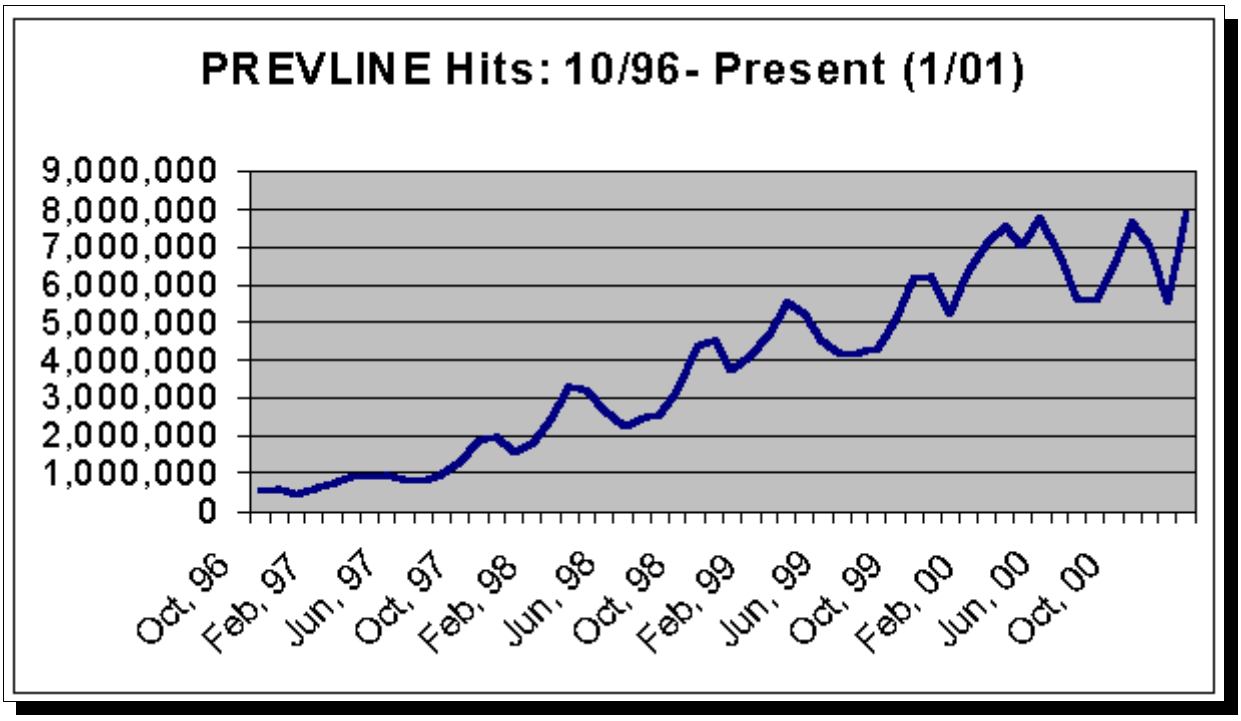
For over a decade, the National Clearinghouse for Alcohol and Drug Information, (NCADI), has served as the Nation's single point of entry in the Federal government for comprehensive, customer-oriented information about substance abuse prevention, intervention, and treatment. It also serves as the response center for the ONDCP National Youth Anti-Drug Media Campaign. NCADI distributes SAMHSA/CSAP/CSAT, NIAAA, NIDA, Department of Education, ONDCP, and other organizational print and audiovisual resources to the prevention, intervention, and treatment field.

NCADI's PREVLINE has evolved into a top-ranked consumer health site. This Web-based service delivers a comprehensive menu of substance abuse prevention and early intervention content to a wide variety of target audiences, including professionals as well as the general public. Some of PREVLINE's accomplishments include:

NCADI Dissemination of Substance Abuse Prevention/Treatment Material: May 1, 2000 through January 31, 2001:

Total contacts were 4,516,230 for an average of 401,803 per month.

- In January, 2001 alone, achieved almost 8 million hits; over 464,000 visitor sessions; an average visitor session length of over 9 minutes.
- Awarded the 8th most popular consumer health site on the Web by Hot100.com in November 2000.
- According to a user survey, seventy-six percent of respondents consider the site "above average"



CSAP will continue to partner with national organizations to promote model programs identified in the Registry. CSAP provides technical assistance and information to national organizations which "adopt" and promote model programs. For example, the Child Development Program discussed earlier, was identified in the Registry as effective in May 2000 and officially adopted and promoted by the National Association of Elementary School Principals (NAESP). This national organization raised awareness of the project to their constituents and supported it through multiple presentations. Current national partners using a variety of models disseminated through the Registry include:

- The National Head Start Association
- National Association of Elementary School Principals
- National Senior Service Corps
- Inner City Games Foundation
- Charles R. Drew Medical School
- Child Welfare League of America
- National Council on Aging

Under NAESP leadership, the Child Development Project, endorsed by the Robert Wood Johnson Foundation, has been replicated in 100 schools in 8 States.

B. Targeted Capacity Expansion

Develop State and Community Capacity

Building on SAMHSA's Goals to assure services availability and to meet unmet and emerging needs, CSAP supports a broad Targeted Capacity Expansion (TCE) program. This next step in CSAP's comprehensive approach helps States and communities address current and specific gaps in availability of substance abuse prevention services and improves the quality of prevention services provided. Programs supported under this strategy are critical to address pervasive or emerging substance abuse problems, to fill current gaps in substance abuse prevention services, and to promote science-based "best practices" in State and community prevention service systems.

State Incentive Grants (SIGs):

The FY 2002 request continues support for the State Incentive Grant (SIG) program. SIGs are the most direct existing mechanism for translating prevention knowledge into practice. The SIG program helps States and communities to implement effective prevention program models identified by NREPP through SAMHSA programs, NIH programs, and foundation supported projects. The average grant size for each SIG State is approximately $3.0 million per year. Eighty- five percent of program funds are channeled to local SIG sub-recipients which include community-based organizations, coalitions, partnerships, local governments, schools, and school districts. A total of 40 States will have received a SIG program by FY 2002. Currently, SIGs have implemented more than 700 science-based substance abuse prevention programs in communities across the Nation. Outcomes anticipated from this program include: statewide (as measured in the NHSDA) reductions in past 30 day tobacco and drug use, and binge drinking; increases in the age of first use; and increases in perception of risk for substance abuse; improved collaboration among State agencies; and increased adoption of science based programs.

According to State surveys, Massachusetts has achieved dramatic reductions in substance use among youth in grades 9-12 including, decreases in alcohol use, cigarette use, marijuana use, and inhalant use. The Single State Authority attributes this reduction to CSAP's programs: a SIG, Block Grant funds, and the use of science based models from NREPP.

The next step in this comprehensive approach is to help States and communities address current and

State Profile: Illinois

Awarded State Incentive Grant 1997 - 2000
Coordinates $59 Million of State and Federal Funds
Last Year - 27 Subrecipients
Systemic Change: Redirected Block Grant Funds into Science Based Prevention Approaches

specific gaps in availability of substance abuse prevention services and to improve the quality of prevention services provided. Programs supported under this strategy are critical to address pervasive or emerging substance abuse problems, to fill current gaps in substance abuse prevention services, and to promote science-based "best practices" in State and community prevention service systems.

Estimated Number of Sub-recipients, Prevention Programs, and Individuals Served
State Incentive Grants FY 1997 - 2002 ($ in millions)

	1997	**1998**	**1999**	**2000**	**2001**	**2002**
No. of States per Year (New/Continuations)	5 (5/0)	14 (14/5)	2 (2/19)	7 (7/16)	9 (9/9)	3 (3/16)
Cumulative No. of States	5	19	21	28	37	40
Sub-recipient Organizations	125	475	525	625	1,025	1,075
Prevention Programs	312	1,187	1,312	1,562	2,562	2,688
Number of Participants	138,437	525,841	581,216	691,966	1,134,966	1,190,784
Total Funds per Year	$15.0	$57.0	$63.0	$60.0	$66.0	$66.0

HIV/AIDS Prevention:
Substance Abuse prevention is HIV/AIDS prevention - 50% of new cases of HIV infection are directly related to substance abuse and 30% of all AIDS cases are directly related to substance abuse. As the experts on substance abuse prevention, CSAP is now bringing this knowledge to communities to address the critical issue of substance abuse-related HIV infections among minority populations. Epidemiological data show that HIV disease continues to disproportionately affect African American and other minority communities. Although the risk of HIV infection among users of injected drugs is well known, users of non-injection drugs such as crack cocaine, alcohol, and methamphetamines are also at greater risk of HIV infection because drug use can affect judgment and interfere with communication, resulting in riskier behavior.

The FY 2002 request continues support for the Centers for the Application of Prevention Technologies (CAPTs). The CAPTs, located in six regional sites, including the Southwest border area, comprise a major national resource supporting the widespread use of scientifically sound and effective substance abuse prevention interventions. The CAPTs have been identified by other federal agencies (e.g., D. of Ed, OJJDP, and ONDCP) as the best resource to provide training for their grantees. CAPTs are essential partners to the SIG program and the Drug Free Community grants funded by ONDCP. CAPTs provide hands-on training and technical assistance to help communities consistently apply current research-based knowledge about effective substance abuse prevention programs, practices, and policies. In FY2000, the CAPTs processed 6771 requests for technical assistance, and exceeded their GPRA target more than two-fold for assisting systemic changes. The predominant changes were implementation of science-based programs and increased coordination.

SAMHSA, through CSAP will continue to focus efforts to prevent minors from purchasing tobacco products. The Synar Amendment aims to reduce the death and disease caused by tobacco use in the Unites States. To that end, the Synar program focuses on prohibiting the sale or distribution of tobacco products to minors in all 50 States, the District of Columbia, and eight U.S. jurisdictions that received Federal substance abuse prevention and treatment funding.

Prior to enactment of the Synar Amendment in 1996, based on community studies, youth under the age of 18 succeeded in purchasing tobacco products from retail stores 60 to 90 percent of the time. Since implementation of the Synar program, States have made great strides in reducing these illegal sales, from approximately 40 percent in 1997 to approximately 20 percent in 2000. Specifically, 24 States have achieved the overall Synar goal of 20 percent or less retailer noncompliance. Additionally, as a result of every State's Synar efforts, the majority of Americans (56.2 percent) live in areas where access to tobacco by youth is limited. States' goal is to achieve and maintain a 20 percent or lower Synar inspection rate during random checks of tobacco sales to youth under age 18.

Identify Needs
The final piece of CSAP's integrated approach is identification of new needs that should be addressed within the other four elements of the comprehensive system. Cross-site and other evaluation findings identify best prevention practices to disseminate to the field, help improve service delivery, and identify gaps in knowledge. Future programs will be designed to fill these gaps. For example, a significant finding from CSAP's cross-site evaluation of the Community Partnership and High Risk Youth grant programs showed unanticipated gender differences in use rates resulting from the different prevention strategies. Highlighting the need for gender-specific interventions, CSAP has

incorporated these interventions within the Community Initiated Intervention (CII) program. The CII program has also been used to address other emerging prevention needs, including programs targeting older adolescents and young adults. Increased usage rates are reflected in data from the National Household Survey. There is also a need for ethnically and culturally relevant prevention programs at critical transition points throughout the lifespan.

Another area CSAP has identified for attention is the lack of fetal alcohol syndrome and fetal alcohol effects (FAS/FAE) programs in communities impacted by this problem. In FY 2000, CSAP supported five State grants designed to support statewide prevention and treatment efforts. The efforts of the five States will serve as valuable test models regarding the efficacy of comprehensive statewide prevention and treatment programs targeting FAS/FAE problems. In FY 2001, CSAP is expanding efforts to identify and disseminate effective prevention models.

In addition, SAMHSA is working to address problems associated with underage alcohol use and adult alcohol abuse. These programs focus on issues such as alcohol availability, advertising, school programs, media education, public awareness and education, violence, college/binge drinking, responsible hospitality, community outreach, drinking and driving, alcohol and prescription drug use, and prevention policies. CSAP efforts reduce underage alcohol use and adult alcohol abuse by developing knowledge, helping States and providers apply research findings to practice, educating the public, collaborating with and supporting the efforts of other agencies, and providing technical assistance and/or other information to substance abuse prevention practitioners. In 2001, CSAP collaborated with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) on a number of prevention projects targeted to youth, young adults, and college students.

To address underage drinking at the national level, SAMHSA supports a multi-year public-private partnership entitled Leadership to Keep Children Alcohol Free. Its purposes include:

- Educate the public about the incidence and impact of early alcohol use by children 9-15 years of age.
- Energize the public to continually address this issue in families, schools, and communities.
- Focus policy makers and opinion leaders on the gravity of the problem.
- Include reduction of underage alcohol use as a national priority.
- Engage all Governors' spouses to be state and national spokespersons for this issue.

FY 2002 Priority Investments . . . . . .

SAMHSA plans to use $32.2 million available in the discretionary funding base to support 83 new and competing grants. These resources are available within the substance abuse prevention grant portfolio as a number of projects conclude in FY 2001. Over the coming year, CSAP will continue to consult with its partners and stakeholders to assure that available resources are directed to meet the most pressing needs of the substance abuse prevention community. The programs proposed for funding below reflect the current professional judgement of the agency and its partners regarding the most pressing program needs for FY 2002. CSAP plans to use available resources primarily to

expand services for existing programs, including allocating $10.5 million for three new State Incentive Grants as 3 projects conclude. This program continues a long and successful history of collaboratively working with the States to promote and improve prevention systems and services at the State, substate and local levels.

In addition, the budget includes $5 million for new Community Initiated Intervention (CII) Cooperative Agreements. The CII program is a critical tool for identifying and filling critical gaps in prevention services throughout the country. While the prevention field continues to develop effective interventions, many of these have not been tested with populations other than those for which they were originally developed. The CII program expands proven prevention practices into diverse settings and populations. The grantees select and adapt prevention interventions that meet the specific prevention needs of the local target population. The CII program enables communities to incorporate recent research findings, such as the need for gender-specific interventions, and address emerging trends, such as substance abuse among the elderly. As more sites implement prevention programs, cross-site evaluations yield more data on what works for varying populations and under what range of circumstances. This information augments the prevention knowledge base and assists other communities in addressing their own prevention needs. At this level, we will fund 20 new grants supporting substance abuse prevention programs around the country.

CSAP also plans to develop effective HIV/AIDS models integrating substance abuse and HIV prevention findings from previously funded programs. A $13.8 million effort, funding 75 sites, will concentrate on institutionalizing services through the established prevention infrastructure created by the SIGs and CAPTS. These supplemental grants will enable SIGS to support services while CAPTs support training and dissemination of effective programs. Program funds will target those communities with high prevalence rates and lack of prevention services. Emphasis will be placed on training community residents to provide intensive outreach services for hard-to-reach populations. This is a critical need in the comprehensive strategy aimed at the health emergency in communities of color and considers the Administration's plan to increase the number of community health centers in underserved communities. Expected outcomes include reduced substance-abuse related HIV infection in targeted communities, improved access to substance abuse and HIV prevention services among hard to reach populations, and increased knowledge of HIV and substance abuse prevention issues among providers and community residents.

The grant portfolio includes $2.2 million to fund 6-8 sites to adapt the Strengthening Early Interventions program to expand and integrate the most promising and successful SESS strategies and methods in new venues. These will include Early Head Start and faith-based early childhood programs, reaching a broader audience of underserved high-risk young children and families. Also, $0.7 million will be available within the High Risk Youth program.

Funding for PRNS during the last five years has been as follows:

	Funding	FTE
1997	$155,869,000	—
1998	$157,000,000	—
1999	$162,800,000	—
2000	$146,705,000	—
2001	$175,013,000	—

Rationale for the Budget Request . . . . . .

The FY 2002 President's Budget request continues this program at the 2001 level.

SUBSTANCE ABUSE TREATMENT
Overview

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
PRNS	$214,390,000	$256,315,000	$256,122,000	+$41,732,000	$296,122,000	+$40,000,000
Block Grant	1,600,000,000	1,665,000,000	1,665,000,000	+65,000,000	1,725,000,000	+60,000,000
Total	$1,814,390,000	$1,921,315,000	$1,921,122,000	+$106,732,000	$2,021,122,000	+$100,000,000

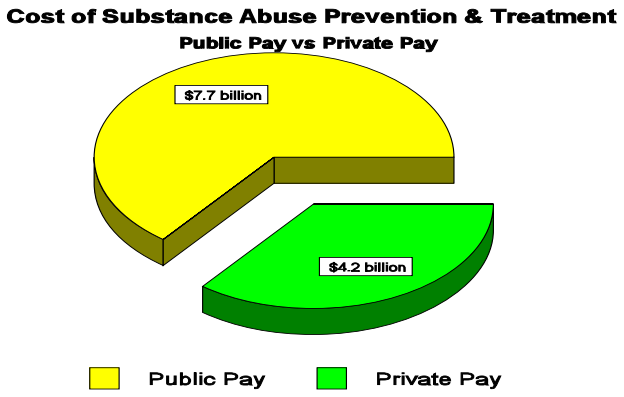
Changing the Conversation

Vision Statement: We envision a society where people with alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated. We envision a society where substance abuse and dependence is recognized as a public health issue, a treatable illness for which individuals deserve treatment. We envision a society where high-quality services for alcohol and drug problems are widely available and where treatment is recognized as a specialized field of expertise.

The problem of substance abuse and dependence has long troubled the Nation, reflecting conflicting concerns for public safety, moral values, and health. Advances in science have reshaped our understanding of addiction and have created an array of effective behavioral and pharmacological interventions, but as the tables below indicate, there are more people in need of substance treatment (including alcohol) than are able to access it. SAMHSA's Center for Substance Abuse Treatment initiated ***Changing the Conversation: A National Plan to Improve Substance Abuse Treatment (NTP)*** to build on recent advances in the field, to bring together the best thinking about improving treatment, and to make recommendations to translate these ideas into practice.

Studies show that, with treatment, primary drug use decreases by nearly 50%. In addition, with treatment, reported alcohol and drug-related medical visits decline by more than 50%, criminal activity decreases by as much as 80%, and client financial self-sufficiency improves (e.g., employment increases, welfare receipt and homelessness decline) (NTIES, 1997).

Estimated annual spending on substance abuse prevention and treatment in 1997 was $11.9 billion. Of this amount, public spending accounted for $7.7 billion or nearly two-thirds, compared to 53% in 1986 (McKusick, et al., 2000).



Through the NTP, CSAT intends to respond to these facts and to a range of national plans and initiatives concerning substance abuse and

health, including *The National Drug Control Strategy* goals for better treatment and *Healthy People 2010*. Five Expert Panels (Closing the Treatment Gap, Reducing Stigma and Changing Attitudes, Improving and Strengthening Treatment Systems, Connecting Services and Research, Addressing Workforce Issues) representing a diversity of knowledge, experience, and views considered previous studies and recommendations, then focused on what should be done next. CSAT sponsored a series of six public hearings around the country.

FY 2002 budget proposals incorporate the collective vision of the participants in the NTP "conversation" over the past year. The FY 2002 budget will: provide an increasing level of funding to support the substance abuse treatment services needs of States, tribes and tribal organizations, towns, cities, and other local entities; provide substance abuse treatment services to critically underserved populations, wherever they exist; and return former substance abusers to full health and to a more productive role in their families, the workforce, and society.

Programs of Regional and National Significance

While treatment is known to be effective, a gap in the availability of treatment continues to exist. For adolescents, the gap is composed of both a lack of treatment services and a treatment system ill equipped to address many of the problems unique to this population. For women, the gap is typically an issue of the need for residential treatment services and accompanying services for infants and children. For those affected by HIV/AIDS, the problem is the need for full integration of services for substance abuse, mental health, primary care and prevention. These are only some of the issues facing the substance abuse treatment community and the nation as a whole.

The problem of alcohol and illicit drug use is so widespread and deeply embedded in the United States that the health care, law enforcement, and criminal justice systems are overwhelmed. To address these problems effectively requires that we mobilize all the resources available in our communities, including effective community coalitions and faith-based groups. In 1993, CSAT initiated a special program to address the inclusion of clergy and other faith leaders in an effort to reduce substance abuse and the problems associated with it. The programmatic approach was to develop a curriculum to provide necessary information and education about illicit drugs, alcohol, and tobacco dependency, the major premise being that informed and educated clergy and religious lay persons are a key to securing and sustaining the involvement of the faith community in addressing the many problems associated with substance abuse. CSAT has continued to sponsor this and other activities to facilitate the involvement of the faith community in substance abuse treatment. This is just one example of ongoing activities involving faith-based organizations.

Substance abuse treatment has been shown to be effective if the right mixture of treatment resources (i.e., providers, modalities, services, etc.) is utilized. In FY 2002, CSAT will continue to work towards the development and implementation of successful substance abuse treatment services in order to reduce the number of substance abusers and the health costs associated with drug use.

Children/Adolescents: Most communities suffer from fragmentation of services for children and adolescents and have extreme shortages of available substance abuse treatment and support services for children/adolescents and their families. Adolescents are one group which is significantly underserved, with only 20 percent of those in need of substance abuse treatment services able to

receive them. Furthermore, evaluations of CSAT adolescent treatment programs have presented findings on the benefits of substance abuse treatment for this population. The Cannabis Youth Treatment (CYT) program evaluated five outpatient treatment protocols and found that all were significantly better than existing practices. Prior to this study, 80% of adolescents treated in outpatient settings had post-treatment outcomes ranging from decreasing use by 15% to increasing use by 10%. The CYT program reported **decreasing use an average of 31%**. Major preliminary findings from the Juvenile/Criminal Justice Network Program were that for adolescents, treatment networks (i.e. social services, education, juvenile justice, primary care) were more effective in providing treatment to older teens (15 years of age and older) and to those arrested for drug related offenses.

The FY 2002 request proposes adding $14.0 million in new efforts to increase substance abuse treatment services for children/adolescents, integrating these services within the existing broad spectrum of services and support. This spectrum includes juvenile justice, school systems, primary health care, mental health treatment, child protective services, foster care and other related systems. This investment will provide age specific treatment services, to include early intervention services for youth who are using but not yet addicted to alcohol and drugs. Of this amount, $8 million is reserved for youth residential treatment.

HIV/AIDS: The Congressional Black Caucus has earmarked funds specifically focused on enhancing and expanding substance abuse treatment services related to HIV/AIDS in African-American, Hispanic, and other racial/ethnic minority communities. Current efforts total $53 million. CSAT supports services to 101 grants to expand substance abuse treatment and HIV services and street outreach to a number of racial and ethnic communities in 22 States in FY 2000 with various high risk population groups. These programs, in a relatively short period of time, have realized substantial success in securing access to substance abuse treatment services, increasing the early access to HAART (Highly Active Antiretroviral Therapy), reducing recidivism, and reaching out to chronic drug users through street outreach programs. In FY 2002, CSAT will continue to fund these programs and focus on population groups which continue to have low rates of utilization of substance abuse treatment, mental health and primary care services, and are over represented among those with multiple risk factors for HIV infection based on high risk sexual and drug using behaviors. These include adolescents, particularly African American and Hispanic, men who have sex with men, and former inmates of the correctional system.

Women: Women are served under a variety of CSAT programs and have been characterized by histories of severe substance abuse, co-occurring mental disorders, histories of physical and sexual abuse, and involvement with the criminal justice and the child protection systems. Preliminary findings from the Women's programs show that 56% of all women treated, and 70% of those who stayed in treatment at least 6 months, were abstinent for the 6-month period after treatment. In addition, women who received help with transitional housing and who attended self-help groups after treatment were more likely to remain abstinent. Existing empirical data confirm that a comprehensive, integrated services approach is effective in treating this population. CSAT continues to fund programs for women through the Targeted Capacity Expansion (TCE) grant program as well as other initiatives, such as the Women, Co-Occurring Disorders and Violence Study.

American Indian/Alaska Native: While some American Indian/Alaska Native (AI/AN) communities have been very successful in competing for treatment funding from CSAT, many have not. In FY 2000, 21 TCE grants ($19.3 million) served AI/AN communities, yet, this population remains significantly underserved. The National Household Survey on Drug Abuse (NHSDA) indicates that the Indian population demonstrates the greatest illicit drug use of all racial/ethnic populations. Jurisdictional differences between tribal and state government often result in a lack of appropriate resources for this population.

In FY 2002, CSAT will continue an American Indian/Alaska Native Community Planning program begun in FY 2001. This program will provide support for tribal community planning and consensus building. These grants will enable recipients to obtain assistance in developing plans for providing substance abuse treatment within their local communities. The plans will describe how tribal governments, organizations providing a range of health and social services to urban Indian populations, and other community organizations will work together to deliver substance abuse treatment and integrate that treatment with HIV/AIDS prevention and treatment, mental health, primary care, and social services.

Criminal Justice: The U.S. rate of incarceration has grown at a decade long rate of about 7% a year, and drugs are implicated in the incarceration of 80% of the people in jail. Dr. Harry K. Wexlar and his colleagues studied recidivism outcomes for offenders who received treatment while incarcerated and then received additional treatment and aftercare in the community. They found that three years after release from prison 27% of offenders who received in-prison treatment and treatment after prison had recidivated, while 75% of offenders in the comparison groups had gone back to prison. Other studies have shown similar results.

In FY 2001, an interagency effort was begun by the Department of Labor, Department of Justice, CMHS, and CSAT. Called *Development of Comprehensive Co-Occurring Treatment Systems for Juveniles and Adults Reentering the Community from Prisons, Jails, or Detention Centers*, the purpose of the CSAT funds is to enable communities to provide effective substance abuse and related services for those people returning to their families and communities. This will include the development of system linkages and referral resources, increased treatment capacity, and ancillary services such as assessment, case management, education, and aftercare. In FY 2002, SAMHSA plans to provide an additional $6 million targeted to teens and young adults being released from the juvenile/criminal justice system.

In FY 2002, CSAT plans to expand by $10 million, funding to Adult, Juvenile and Family Drug Courts. Drug Courts continue to expand rapidly around the country and are seen as an effective way to help drug users regain control of their lives while reducing the overall cost to the taxpayers. For example, it is now the policy in the New York court system that all persons involved with the courts should be provided treatment when appropriate, and drug courts are seen as the primary tool. The problem is that while drug courts have expanded dramatically throughout the country (there are now more than 700), there has not been a concurrent expansion in the availability of treatment resources for these courts and the communities they serve. The most glaring funding shortage for drug courts is funding for clinical interventions.

Homeless: In response to concerns that substance abuse among the Nation's homeless population remains a serious problem that requires additional attention, and that existing addiction services are not adequately addressing the unique needs and life circumstances of homeless persons, in FY 2001, CSAT initiated a $10 million *Addictions Treatment for the Homeless* program. An estimated 25-40 percent of homeless people need programs to help them recover from drug and alcohol abuse illnesses. SAMHSA's goal is to enhance and strengthen substance abuse treatment within a seamless system of services (i.e., primary care, mental health, housing, and other social services) for this population. In FY 2002, CSAT intends to increase treatment funding for the homeless by $4 million and continue to focus on connecting the systems which are critical for the success of substance abuse treatment.

Co-Occurring: People with co-occurring addictive and mental disorders are a large and significantly underserved population. Based on the Epidemiologic Catchment Area (ECA) survey and the National Comorbidity Survey, about 10 million people in this country will have at least one diagnosable mental disorder and one co-occurring substance abuse disorder in any year. Patients with mental, drug, or alcohol disorders appear in both systems and often are missed or mis-diagnosed. Because many people with co-occurring disorders are homeless or are involved in the criminal justice system, CSAT, through the National Treatment Plan, strongly recommends a "no wrong door" strategy to ensure effective and appropriate care for all individuals. In FY 2002, CSAT plans to continue efforts for this population through the TCE grant program and Treatment Models for People with Co-occurring Substance Abuse and Mental Health Disorders.

Opioid Treatment: SAMHSA/CSAT and the Food and Drug Administration (FDA) have collaborated over the past three years to transition DHHS oversight of methadone and LAAM treatment programs from FDA to CSAT. The final rule was published January 17, 2001. CSAT and FDA have continued to facilitate the transition of responsibilities and activities. Until the rule becomes effective, CSAT will continue working with FDA and the State Methadone Authorities to facilitate the change of responsibilities. In FY 2001, implementation of the national accreditation system for opioid treatment programs will begin and will accelerate in FY 2002. CSAT is taking a leadership role in working with key medical organizations and State licensing boards and narcotic drug control authorities to assure consistent, quality opioid treatment, and plans to train 4,000 physicians by the end of FY 2002. CSAT continues to move ahead with its effort to develop treatment guidelines and a physician training curriculum in anticipation of new treatment medications, such as buprenorphine and buprenorphine NX. The first pilot presentation of the CSAT curriculum was at the American Association of Addiction Psychiatry Conference in December, 2000, where 100 physicians completed the education class.

Training and Technical Assistance: The National Treatment Plan identified the need for training and technical assistance efforts throughout the five panels. Some of the recommendations from the NTP were already in place. CSAT will continue to fund Addiction Technology Transfer Centers (ATTCs) at the FY 2001 level of $7 million to ensure those working in the treatment field have access to the most current knowledge needed to provide effective treatment services. The ATTC program is multi-disciplinary in scope, encompassing addictions counseling and a minimum of three other related disciplines such as medicine, nursing, social work, marriage/family therapy, and criminal justice. The ATTCs also provide training of treatment providers in areas such as cultural

competence, assessment, and monitoring processes. The current network of 13 geographically disbursed ATTCs covers 39 States, the District of Columbia, Puerto Rico, and the Virgin Islands. The purpose of the technical assistance activities supported by CSAT is to promote the transfer of knowledge and assist grantees in the development and implementation of the programs. There are technical assistance contracts which support the discretionary grant programs such as the Targeted Capacity Expansion program, the Exemplary Treatment Models programs for Adolescents and Co-occurring populations, and the Methamphetamine Treatment program. These contracts provide such support as consultation, data and analytic activities, development and implementation of training activities, and development and evaluation of program products to grantees in order to advance the utilization of the most recent research and findings in the field of substance abuse treatment.

Other: Other discretionary activities planned for continuation in FY 2002 include the Practice Improvement Collaboratives, the RecoveryCommunity Support Program, Community Action Grants, and a new activity, Services Integration and Development of Systems of Care - State Incentive Grants. These program activities are discussed in further detail in the PRNS section. In addition, there are several major evaluation studies and knowledge transfer activities in process. These include:

- ***Persistent Effects of Treatment Studies (PETS)*** - A primary set of follow-up studies evaluating the long-term effectiveness (up to 36 months) of substance abuse treatment services.

- ***Knowledge Application Program (KAP)*** - The means by which the knowledge developed through a broad array of CSAT-sponsored activities (including grants, cooperative agreements and contracts) is recorded and/or developed, transformed into products, marketed and disseminated to substance abuse treatment professionals, professionals in related fields and consumers. Examples include the *Treatment Improvement Protocols (TIPs)*, *CSAT by Fax*, *Substance Abuse in Brief*.

- ***National Evaluation Data Services (NEDS II)*** - Covers three different yet highly compatible and interlinked data activities: (1) GPRA data pooling, analysis and reporting; (2) state administrative data system development, data acquisition and pooling, and analysis using web-based technology; and, (3) secondary analysis of existing data resources.

Programs of Regional & National Significance
Program Distribution of Funds
(dollars in thousands)

	FY 2000	FY 2001	FY 2002
Substance Abuse Treatment:			
Children/Adolescents	$16,502	$15,923	$33,988
HIV/AIDS	44,982	57,187	59,187
Women	25,201	24,879	28,979
American Indian/Alaskan Native	25,658	27,002	23,250
Criminal Justice	7,861	15,076	23,372
Homeless	2,015	13,130	16,000
Co-Occurring	7,058	9,457	7,575
Opioid Treatment	9,294	10,175	11,281
Training & Technical Assistance	15,178	12,249	14,059
Other	60,641	71,044	78,431
Total	$214,390	$256,122	$296,122

Block Grant and Formula Grant Programs

Substance Abuse Prevention and Treatment Block Grant (SAPT Block Grant): The President's request includes an increase of $60 million for the SAPT Block Grant in FY 2002. The 4,800 additional persons served with block grant funding, together with persons served by proposed PRNS increases will direct much needed resources toward reducing the drug treatment gap of 2.9 million persons.

Persons Served with SAMHSA/CSAT Funding

	FY 2000	FY 2001	FY 2002
PRNS			
Persons Served	67,199	83,474	95,217
Number of Grants	376	472	526
SAPT Block Grant			
Persons Served	330,970	337,390	342,194
Number of Grants	60	60	60
Total Persons Served	398,169	420,864	437,411
Total Awards	436	532	586

Center for Substance Abuse Treatment
Budget Mechanism Table
(Dollars in Thousands)

	FY 2000 Actual		FY 2001 Appropriation		FY 2002 Request	
	No.	Amount	No.	Amount	No.	Amount
Programs of National and Regional Significance:						
Grants/Cooperative Agreements:						
Continuations	216	$93,875	264	$117,869	327	$132,043
New/Competing	156	69,298	208	72,696	199	97,342
Supplements	4	223	---	---	---	---
Subtotal	376	163,396	472	190,565	526	229,385
Contracts:						
Continuations	42	35,640	55	33,009	78	58,922
New	80	13,450	112	29,158	5	4,050
Technical Assistance	21	437	34	1,465	31	1,265
Review Cost	26	1,467	32	1,925	48	2,500
Subtotal	169	50,994	233	65,557	162	66,737
Total, PRNS	**545**	**214,390**	**705**	**256,122**	**688**	**296,122**
Substance Abuse Block Grant	**60**	**1,600,000**	**60**	**1,665,000**	**60**	**1,725,000**
(Block Grant Set-aside: Non-add)	—	*(80,000)*	*(0)*	*(83,250)*	*(0)*	*(86,250)*
TOTAL, CSAT	**605**	**1,814,390**	**765**	**1,921,122**	**748**	**2,021,122**

Center for Substance Abuse Treatment
Programs of Regional and National Significance (PRNS)

Authorizing Legislation - Sections 509, 514, and 1971 of the Public Health Service Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
PRNS	$214,390,000	$253,815,000	$253,622,000	+$39,232,000	$278,622,000	+$25,000,000
SAT Svcs for Child & Adoles	—	2,500,000	2,500,000	+2,500,000	16,500,000	+14,000,000
Data Infrast	—	—	—	—	1,000,000	+1,000,000
Total	$214,390,000	$256,315,000	$256,122,000	+$41,732,000	$296,122,000	+$40,000,000

2002 Authorization ..... Such Sums as Necessary

Purpose and Method of Operation .....

Public Law 106-310, the Children's Health Act of 2000, October 17, 2000, reauthorized SAMHSA programs. Among the many aspects of the law, it amends or repeals entirely several older discretionary programs and establishes a new discretionary authority for the Secretary to address priority substance abuse treatment needs of regional and national significance. This approach provides the Secretary flexibility to respond to the needs of people in need of substance abuse treatment. Three separate types of activities are authorized under the new law: (1) knowledge development and application projects which are used to develop more information on how best to serve those in need; (2) training and technical assistance to disseminate the information knowledge development; and (3) targeted capacity expansion programs which enable the agency to respond to service needs in local communities. Also addressed is the importance of the interface between substance abuse treatment services and primary care.

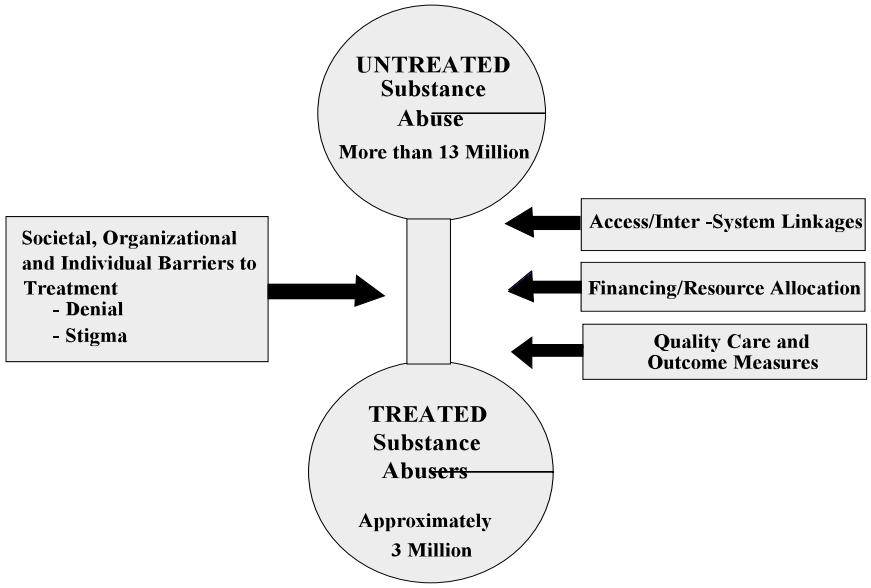
Knowledge development and application projects: The mission of CSAT is to ensure that people who suffer from substance abuse problems get the most effective treatment services available, when and where they need them. To this end, SAMHSA focuses on bridging the gaps between federal and State needs and resources, between research and practice; between substance abuse professionals and their counterparts in other social services systems; and, most importantly, between the drug addicted individual and drug treatment services. The objective of the National Treatment Plan (NTP) process is to stem alcohol and drug use and abuse by fostering ongoing improvement in the quality and availability of treatment services for substance abuse and dependence.

The NTP process will facilitate States, counties, cities and local communities to build on recent advances in the field, by bringing together the best ideas about improving treatment, and through identification of action recommendations that can translate theories into practice. Substance abusing/addicted persons present in a wide variety of human services, health, or justice system settings. Although progress has been made in the development of integrated systems to identify and

provide treatment for substance abuse, most communities and States need further development and integration of their systems of care to deliver services in a comprehensive, timely, and effective manner.

Multiple barriers, as shown in the figure below, impede access to substance abuse treatment services, including individual, social, organizational, and financial barriers. Individual barriers may include denial of the disorder by the client or lack of recognition of the client's problem by other health care workers. The need for transportation to the treatment site, child care while attending treatment, or the need for a Spanish (or other language) speaking treatment provider are examples of social barriers. In addition, some persons in need of treatment may not be able to afford it, or may not have insurance coverage that is adequate for individual treatment needs.

The findings and recommendations of the National Treatment Plan emphasize the benefit of multiple systems working together to ensure that appropriate effective care is available to all individuals in need of treatment. Based on the "every door a right door" approach, no matter where in the human services, health, or justice systems an individual presents, his/her alcohol or drug problem will be appropriately identified, assessed, referred, or treated.



Effective treatment and the wise use of resources require a commitment to improve the quality of care. Treatment programs must incorporate new research results in their treatment practices, implement quality improvement systems and performance standards, and employ well-trained staff. Practice concerns must help inform the NIH research agenda, and new knowledge must move swiftly and effectively from research into application. This interactive process should establish evidence-based practices, treatment and management standards, performance measures and quality indicators as well as training programs for staff.

The National Treatment Plan process identified a number of priorities to improve substance abuse treatment quality:

- establishing a system to connect services and research, which has as its goal the provision of treatment that is based on the best research evidence;

- developing commonly accepted standards for the treatment field, which include evidence-based standards for quality of care and practices that apply to all systems and payors;

- achieving consensus on critical data elements to measure quality of care and treatment outcomes for payors and providers;

- establishing standards for education, training and credentialing of all treatment professionals; and,

- attracting, supporting and maintaining a competent, diverse workforce, responsive to the client population.

CSAT's unique Practice Improvement Collaboratives (PIC) program is a very practical effort to help community-based providers improve the quality of substance abuse treatment services. Community partnerships are formed for the purpose of implementing evidence-based practices in community-based organizations. Each collaborative supports the implementation of best practices, evaluates different methods of implementation, involves multiple partners in setting and carrying out a knowledge adoption agenda, and serves as an ongoing resource for practice improvement needs of community-based treatment providers. Systems that promote consistent communication and collaboration among service providers, academic institutions, researchers and other relevant stakeholders, have been found to be most successful when they focus on the interdependent functions of knowledge development, transfer and application – emphasizing application in practice.

Knowledge development programs address the determination and documentation of quality treatment standards. CSAT has sponsored the development and refinement of a number of treatment protocol manuals for different target populations (e.g., methamphetamine users, adult marijuana users, homeless persons experiencing problems with alcohol and drug use, adolescent marijuana users) for community based providers. Similarly, NIDA and NIAAA have sponsored the development of such manuals for treatment of opiate, cocaine, and alcohol dependence, but these must be moved into community based provider organizations to be effective. As part of the research to practice cycle, the effectiveness of these treatment protocols needs to be further examined within an expanded set of treatment programs using a standardized outcomes monitoring approach. Treatment protocols and standards setting must be a collaborative process, involving all relevant stakeholders.

The standards will support treatment that responds to the unique needs of individuals and families from different population groups, that is client-centered, respectful and empowering to the individual, and free from the stigma often associated with alcohol and drug problems. Standards will be based on the best evidence, and provide for continuing improvement. At the same time, the design of standards and quality assurance and improvement systems must incorporate consideration of implementation costs.

Training and technical assistance to disseminate the information through knowledge development: The objective of providers in the field to guarantee delivery of optimum care, together with the recent connection between provider reimbursement and education levels, calls for a formal strategy and defined standards for training substance abuse treatment staff. Through operation of a network of *Addiction Technology Transfer Centers (ATTC)*, CSAT promotes an NTP goal of attracting, training,

supporting, and maintaining a competent, diverse workforce, responsive to the client population. The need for basic education and training standards is widely supported for new substance abuse treatment practitioners entering in the field. The field has also begun to address the need for standards for basic and continuing education through projects such as the *Addiction Counseling Competencies*. Other key workforce issues include improved compensation, career ladders, and staff development.

Maintaining an adequate supply of competent substance abuse treatment staff who are trained to practice at specified levels and who can address complex needs of diverse client groups is critical for access to quality substance abuse treatment services. CSAT has been asked to help establish a minimum workforce data set and develop a framework for periodic data collection, collect the data, develop a computerized workforce database, and analyze the data by a variety of criteria.

Pervasive negative attitudes surround people seeking treatment and those in recovery. First, is the underlying stigma attached to people with alcohol and drug problems, people in or seeking recovery and their families, significant others, and support networks. Second, is the persistent but mistaken impression that treatment does not work. Third, is the tendency to confuse the illness with behavior that may constitute indications, symptoms, or results of the illness. Finally, people with alcohol or drug problems often suffer from additional compounding stigmas--based on race, ethnicity, gender, sexual orientation, and other factors. States, counties, cities, tribes, local communities, and community based organizations have asked through the National Treatment Plan process for assistance in addressing this issue.

Alcoholism and drug dependence are diseases and public health problems. The findings and recommendations of the National Treatment Plan process clearly point to the need for the development and implementation of specific stigma-reduction activities, as well as efforts to organize the recovery community and build its capacity to engage in public dialogue and education. CSAT's current *Recovery Community Support Program (RCSP)* supports both goals, and includes stigma-reduction approaches and models that can be implemented by local recovery community groups and others in the addiction treatment and recovery field. RCSP goals are to create a more accepting and caring attitude within States, counties, cities, tribes and local communities, to encourage more people to seek substance abuse treatment and accept personal responsibility for their recovery, and to discourage substance abuse in American society.

The RCSP will also support organizations or programs comprised of and led by people in recovery and their family members and other allies to develop, implement, and evaluate the effectiveness of local stigma-reduction strategies consistent with the findings and recommendations of the National Treatment Plan. Projects will pioneer approaches to stigma reduction based on messages and processes tailored to the specified target audience and specific jurisdictions. Knowledge gained will provide the foundation to develop public education materials and messages that the recovery community and others in the field can incorporate into anti-stigma efforts to assist States, counties, cities, tribes and local communities in their activities.

CSAT will encourage the faith community to apply for federal funding for treatment projects and fund training-related projects to expand and enhance the knowledge and skills of faith communities in complex substance abuse and mental health issues, including new approaches for outreach, and

provide medical and psychiatric referral support, and effective methods to promote cooperation and collaboration among the faith, substance abuse treatment, and public health communities. This builds on the results of CSAT's prior Faith-Based Project that grew out of the Target Cities demonstration program. The objectives of this project are threefold:

- Outreach--To work with religious organizations to enhance the treatment potential within communities;

- Education--To work with educational institutions to increase the potential for treatment education among the clergy;

- Resources Allocation--To provide resources for knowledge application grantees to enhance their ability to network, collaborate, plan, implement, and evaluate their faith community efforts.

Targeted capacity expansion programs to respond to service needs in local communities: A report by the Physician Leadership on National Drug Policy (PLNDP) supports the position that treatment is effective in reducing the number of persons who are dependent on illegal drugs. The implementation of CSAT's TCE program has helped communities to address the scourge of substance abuse. TCE activities help to reduce the treatment gap, provide funding assistance to communities where there are emerging drug problems, and support rapid and strategic responses to the demand for substance abuse treatment services that are local and regional in nature. Examples of this include expansion of specialized services for women in three regions of Colorado, especially underserved rural areas; expansion of outpatient methadone treatment in the under-represented areas of Chicago; and expansion of medical and non-hospital detoxification services in Philadelphia. In FY 2001, CSAT will award approximately 147 new TCE and TCE-HIV/AIDS grants. All TCE program announcements will encourage applications from community and faith-based organizations, as studies have shown that these organizations can be a powerful tool in helping individuals overcome drug and alcohol addiction.

FY 2002 Priority Investments . . . . . .

In FY 2002, CSAT will invest $61 million in new competitive projects from resources available within the substance abuse treatment services program base as a number of projects conclude in FY 2001. Over the coming year, CSAT will continue to consult with its partners and stakeholders to assure that available resources are directed to meet the most pressing needs of the substance abuse treatment community. The programs proposed for funding below reflect the current professional judgement of the agency and its partners regarding CSAT's most pressing program needs for FY 2002.

CSAT plans to allocate a total of $5 million for the **Recovery Community Support Program (RCSP)** and the **Comprehensive Community Treatment Program (CCTP).** The CCTP is a program designed to allow treatment providers and other experts in the substance abuse treatment field the opportunity to identify innovative clinical and service delivery approaches in need of study and development.

In FY 2001, CSAT began to develop, plan, and implement a new program, **Rehabilitation and Restitution**. In FY 2002, $2.0 million in funding will be used to support knowledge development and systems change activities toward the implementation of a sophisticated, multi-system program for substance abusing offenders. This program will provide the opportunity for certain non-violent substance abusing felony offenders to: 1) recover from their addiction; 2) provide restitution to victims and the community, by performing community service and responding to victims concerns when appropriate; and 3) become more fully functioning citizens of the United States with the opportunity to regain all the privileges of citizenship. The goals of this program are to improve treatment retention and outcome, reduce criminal activity which also reduces victimization, and assist program clients in becoming more fully functioning citizens.

CSAT plans to award new grants of $19 million comprised of **Planning Grants**, **Community Action Grants, Practice Improvement Collaboratives,** and **TCE**. In FY 2002, CSAT will expand this continuum of services and provide for a range of needs at the community level, all directed toward providing effective drug treatment efficiently.

This program continuum provides opportunities for the range of activities for communities in need, from bringing communities to consensus around adoption of a proven treatment model, to developing linkages of existing services in order to improve the quality and efficiency of delivery and reduce drop-out and recidivism, and finally, to support the provision of services where demonstrated need exists.

The findings and recommendations of the National Treatment Plan emphasize the benefit of multiple systems working together to ensure that appropriate effective care is available to all individuals in need of treatment. Major themes throughout the NTP include the need for large scale systems development and integration and adopting best practices and commonly accepted standards for the treatment field based on evidence and science. Such complex, multi-dimensional activities must be ongoing processes with careful planning, and often, staged implementation. In response to this need, as identified in the NTP, CSAT is proposing an $8 million reinvestment effort in FY 2002 for the award of 8-10 **State Incentive Grants (SIG)** . Following the NTP, CSAT plans to consult with State representatives, providers and other stakeholders in developing this program. The program would be designed to provide incentives for States to take the lead in implementing best practices across the range of NTP issues. For example, States and their partners might focus on:

- creating strong inter-system linkages among substance abuse treatment, mental health and primary health care, criminal justice, welfare, employment and other systems to better meet the complex needs of persons with severe drug and alcohol problems;

- developing and strengthening a comprehensive infrastructure that attracts, supports, and maintains a competent, diverse workforce;

- facilitating participation of those in recovery and their family members in the planning, design, delivery and evaluation of addiction treatment and recovery policies, systems and services;

- assessing findings developed from research and knowledge development efforts and translating evidence-based practices for field application.

In FY 1999, funds were provided with the support of the Congressional Black Caucus to address the HIV/AIDS crisis existing in communities of color. In response to this and increasing numbers of AIDS cases among racial and ethnic minority populations, CSAT awarded **TCE/HIV** grants to community-based organizations to augment, expand and enhance substance abuse treatment services, HIV/AIDS services, and other infectious disease services. In addition, **HIV Outreach Projects** were awarded designed to target hard-to-reach, high risk substance abusers with preventive health and behavioral risk information and to facilitate their early entry into substance abuse treatment. New projects were funded under the TCE/HIV program in FY 2000 and 2001. The startling rates of increase of HIV and AIDS among racial and ethnic minority populations, the subsequent declaration of a health emergency by the Surgeon General, and current data indicate the HIV/AIDS health crisis has not abated nor has realized a demonstrable change in the epidemiology of HIV/AIDS. CSAT plans to reinvest $23 million in FY 2002 funding for those programs first funded in FY 1999. These grants have engendered trust, cooperation and collaboration within communities where cynicism, fear and distrust are common and continuation of their specialized services is a necessity.

In FY 2002, CSAT plans to invest $1 million for **Data Infrastructure Development** from resources available within base level funding. The Children's Health Act of 2000 authorizes SAMHSA to provide funding to States for the purpose of developing and operating substance abuse data collection, analysis, and reporting systems with regard to performance measures including capacity, process, and outcome measures. This effort will allow States to build the substance abuse treatment data infrastructure necessary to implement a performance based system to allow for initiation of Performance Partnership Block Grants. CSAT plans to make approximately 10 awards to States who have often reported that they lack the data infrastructure needed to report performance measures.

Finally, CSAT plans to award $3 million to continue contract support for the substance abuse treatment field and community programs. This includes training agencies and providers in the proper maintenance of patient records for purposes of confidentiality; community forums to develop and support events for National Alcohol and Drug Addiction Recovery Month; and evaluation activities of new programs for clinical use of opioid treatments such as buprenorphine and buprenorphine/naloxone.

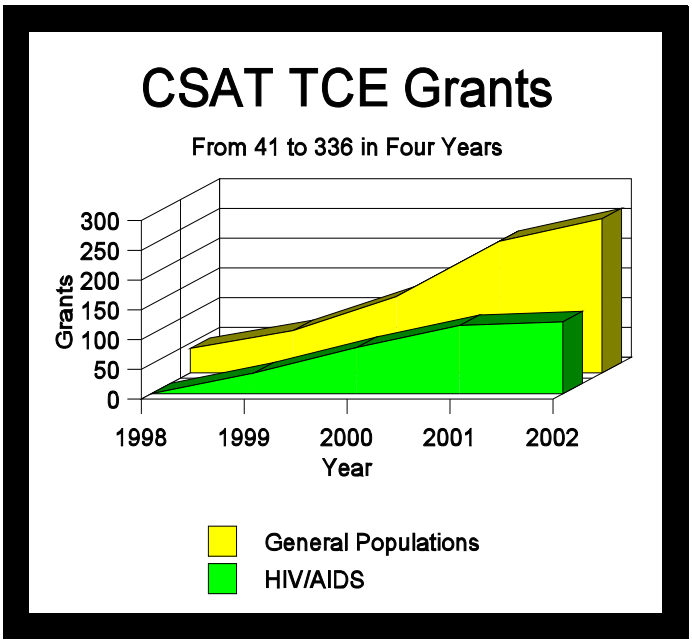
Funding for PRNS during the last five years has been as follows:

	Funding	FTE
1997	$155,868,000	—
1998	155,868,000	—
1999	170,386,000	—
2000	214,390,000	—
2001	256,122,000	—

Rationale for the Budget Request . . . . . .

The President's Budget request includes an increase of $40.0 million for PRNS for an FY 2002 program total of $296.1 million, or an increase of 15.6%. All of the increase will be allocated to support new TCE projects, funding approximately 54 new discretionary grants. The new projects will provide substance abuse treatment services for approximately 12,000 persons. Increased PRNS resources will focus on high-risk populations and high-need communities as follows:

- Treatment services for teens and young adults, including both residential and outpatient treatment ($14 million): No more than one of every five adolescents in need of treatment services receive them. A recent survey in the State of Minnesota showed that only 18% of adolescents in need of substance abuse treatment receive services. The majority of services for adolescents are provided to those referred from the juvenile justice system (over 40% according to the most recent TEDS data). This shuts out many adolescents from services who do not develop problems severe enough to bring them to the attention of the juvenile justice system. SAMHSA's goal is to build the capacity of communities to provide for youth and young adults (up to the age of 24) substance abuse treatment services which are evidence based and cost-effective, matching youth and their families with the appropriate level and intensity of care.



Of particular focus for adolescents and young adults is alcohol and alcohol abuse. CSAT and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) are jointly funding a program to contribute to the identification and development of efficacious treatment interventions and services to adolescent alcohol abusers and alcoholics. This activity is critical because adolescent treatment has so far been experientially-based and not evidence-based. It is extremely important to continue to provide information to the addiction field not only to stimulate research on adolescent treatment but to provide guidance on how to achieve the best outcomes for this population. The lessons learned from current grantees will be invaluable to the process of moving research into practice.

- Expand treatment capacity to support adult and juvenile justice and family drug courts ($10 million): When a person is in drug treatment court they are under intense supervision, and failure to comply with the terms of the program, especially making progress in treatment, can result in reincarceration. Drug court clients are disproportionately minority and poor, and the

drug court model is now the dominant court-based method for diverting these clients from incarceration to treatment. However, there is a clear lack of culturally-specific and gender-specific treatment, causing unacceptable rates of relapse. The Drug Court Program Office, Department of Justice, has identified the lack of culturally specific programs for young African-American males as a problem needing to be addressed and that juvenile treatment programs associated with drug courts are particularly weak. While drug treatment courts have expanded dramatically throughout the country, there has not been a concurrent expansion in the availability of treatment resources for these courts.

In FY 2002, CSAT will expand new clinically-based treatment and related services to address the gap in available drug court treatment services. The goals of the **adult drug treatment court** activities will be to reduce substance use, improve the general health of minority men and women, reduce the crime rate, and reduce the percentage of adults who are reincarcerated. The goals of the **juvenile drug treatment court** activities will be to reduce substance use, improve the general health of juveniles, reduce the crime rate, and reduce the percentage of juveniles put into institutions. The goals of the **family drug treatment court** activities will be to reduce substance use, reduce the time taken for final disposition of abuse and neglect cases, increase the percentage of family reunifications, increase family functioning, and eliminate future neglect and abuse of children.

- Re-Entry Programs for adolescents returning from detention facilities to the community ($6 million): There is a substantial shortage of treatment available for adolescents and young persons, especially those involved with the justice system, and well over half of adolescents and young persons returning from detention facilities, prisons, or jails are substance abusers or are substance dependent. This is a high need population, at serious risk for re-offending and entering the adult prison system. Providing treatment may be the last best hope for intervening with these adolescents and young persons, who are disproportionately minorities. The Department of Justice, the Department of Labor, and SAMHSA are jointly funding a $71 million re-entry project for FY 2001 (SAMHSA funding is $8 million). DOJ and DOL also are requesting additional funds in FY 2002 for new Re-entry grants, and funds from the CSAT FY 2002 request would be committed to new treatment efforts serving adolescents and young persons, through age 24, as part of the continuing DOJ, DOL and SAMHSA collaboration.

- Treatment programs for the homeless ($4 million): An estimated 25 to 40 percent of homeless people need programs to help them recover from drug and alcohol abuse illnesses. The goal of the homeless program is to enhance and strengthen substance abuse treatment within a seamless system of services (i.e., primary health care, mental health, housing, and social services). The target population includes homeless individuals with substance abuse disorders or with co-occurring substance abuse and mental disorders. This program is intended to help communities by strengthening the treatment service infrastructure, and the continuum of care. The FY 2002 request increases TCE - Homeless funding to $14 million. These homeless treatment efforts will be guided by outcomes from previous SAMHSA/CMHS/CSAT collaborations, the *Homeless Prevention* grant program, CMHS's *ACCESS Program*; and from lessons learned from NIAAA, NIDA, and other federal homeless efforts.

- TCE programs for the general population ($6 million): To sustain momentum, all projects funded by the PRNS requested increase in FY 2002 will increase services capacity, both to target the special populations as outlined above, and infuse more funding for treatment needs of the "general" population. Previous projects, such as treatment for use of inhalants or methamphetamine abuse, have helped to match urgent and emerging community needs with federal funding. These programs provide resources to support substance abuse treatment services for thousands of persons who likely would not otherwise receive the care that they need. TCE-funded programs are critical for responding to particular needs and gaps in treatment that cannot be adequately met by the Substance Abuse Prevention and Treatment Block Grant.

CSAT's total TCE portfolio in FY 2002, including the above activities, will total $201 million and will be comprised of approximately 380 grants serving an estimated 77,000 persons.

As part of the TCE portfolio, a client outcome assessment strategy will collect a uniform set of data elements (measures) from each individual, at admission to services, and at 6 and 12 months after admission. The outcomes (as appropriate) that will be tracked using this data are:

- Percent of adults receiving services who:
  a) were currently employed or engaged in productive activities
  b) had a permanent place to live in the community
  c) had reduced involvement with the criminal justice system
  d) had no past month use of illegal drugs or misuse of prescription drugs
  e) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs

- Percent of children/adolescents under age 18 receiving services who:
  a) were attending school
  b) were residing in a stable living environment
  c) had no involvement in the juvenile justice system
  d) had no past month use of alcohol or illegal drugs
  e) experienced reduced substance abuse related health, behavior, or social consequences.

PROGRAM ACCOMPLISHMENT

Targeted Capacity Expansion Program

Preliminary Findings and Results: The preliminary findings and results presented here are from the first 41 grantees awarded in FY 1998. There are 4,912 clients included in the reported data.

Drug and Alcohol Use: An important objective of the grant program is to reduce the use of alcohol and other illegal drugs. The data show a decrease by at least 50 percent in the number of days program clients report using alcohol and other illegal drugs.

- Mean Number of Days of Alcohol Use
  - Intake: 4.9
  - 6-month follow-up: 1.6

- Mean Number of Days of Alcohol Use to Intoxication (5+ drinks in one setting)
  - Intake: 2.8
  - 6-month follow-up: 0.9

- Mean Number of Days of Other Illegal Drugs Use
  - Intake: 8.1
  - 6-month follow-up: 3.5

Crime and Criminal Justice Status: Another objective for TCE is to reduce criminal activity. The number of times program clients have been arrested and the number of nights spent in jail have decreased from intake to the six month follow-up.

- Mean Number of Times Arrested
  - Intake: 0.4
  - 6-month follow-up: 0.08

- Mean Number of Nights Spent in Jail
  - Intake: 2.3
  - 6-month follow-up: 0.7

Employment: The TCE program expects to increase the number of clients who are employed. The percentage of clients fully employed increased 25 percent from intake to the six-month follow-up. Part-time employment increased by over 41 percent.

- Employment at intake
  - Full time: 15.6%
  - Part time: 8.7%

- Employment at six month follow-up
  - Full time: 19.5%
  - Part time: 12.3%

Family and Living Conditions: The TCE program also focuses on improving living situations. Clients reported reduced stress levels, less frequency in giving up important activities, and fewer emotional problems at follow-up compared to intake.

- How Stressful Have Things Been Because of Alcohol or Other Drugs
  - Intake (extremely stressful): 18.6%
  - 6-month follow-up (extremely stressful):10.3%

- Reduce or Give Up Important Activities Because of Alcohol or Other Drugs
  - Intake (extremely): 15.0%
  - 6-month follow-up (extremely): 6.2%

- Have Emotional Problems Due to Alcohol and Other Drugs
  - Intake (extremely): 14.8%
  - 6-month follow-up (extremely): 5.7%

Housing Status: The TCE program also expects to improve living conditions so more clients are living in their own homes; someone else's apartment, room, house, or halfway house; or residential treatment. More clients reported living in a housed environment at follow-up than at intake.

- Living Most of the Time in a Housed Environment
  - Intake: 84.3%
  - 6-month follow-up: 90.6%

PROGRAM ACCOMPLISHMENT

HIV/AIDS Outreach Program

Studies have shown that people at risk for HIV/AIDS because of their drug use behaviors can be successfully engaged in substance abuse treatment programs through carefully designed public health outreach efforts. As reported in a special issue of the journal, ***Evaluation and Program Planning***, September, 1999, results from CSAT's previous AIDS Outreach Demonstration Project which ended in FY 1997, confirmed that outreach programs were able to effectively reach substance abusers at high risk for HIV infection and help them get into drug treatment programs in the early stages of their substance abuse histories.

An analysis of 1,675 clients in these previous Outreach Projects was compared to 3,704 subjects of other studies. Results indicate hard-to-reach populations are more likely to enter substance abuse treatment through participation in HIV outreach programs than clients recruited specifically for treatment. Even clients with criminal records with no permanent address, could be convinced to practice less risky behavior if confronted with the risks of HIV/AIDS.

HIV/AIDS Outreach Program:

- begun in FY 1999 to address the need for community-based projects in African-American, Latino/Hispanic and other racial/ethnic minority communities;

- expected to effect drug using behavioral change and encourage treatment among high risk substance abusers by successfully employing outreach techniques/approaches;

- eligible organizations had to be located in a Metropolitan Statistical Area with an AIDS annual case rate of 20/100,000 population or in a State with an AIDS case rate of 10/100,000 population;

- Significant accomplishments have been achieved to date:
  - -- conducted 89,560 individual and group contacts;
  - -- referred 3,957 individuals for HIV testing;
  - -- made 1,970 referrals for substance abuse treatment.

- Program goals:
  - -- reduce the transmission of HIV among drug users by assisting out-of-treatment injection drug users (IDUs) in adopting risk reduction and safe-sex practices;
  - -- provide access to substance abuse treatment and health education:
  - -- make available medical diagnostic testing and screening for HIV, STDs, TB, hepatitis, and pregnancy;
  - -- provide linkages and follow-up to medical, mental health, and social services;
  - -- make outreach and follow-up services available through the use of mobile vans where IDUs congregate and at drop-in centers;
  - -- demonstrate efficacy of the outreach model as an intervention for facilitating access to substance abuse treatment.

Substance Abuse Prevention and Treatment Block Grant

Authorizing Legislation - Section 1921 of the Public Health Service Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
SAPT Block Grant	$1,600,000,000	$1,665,000,000	$1,665,000,000	+$65,000,000	$1,725,000,000	+$60,000,000

2002 Authorization ..... Such Sums as Necessary

Purpose and Method of Operation .....

The purpose of the Substance Abuse Prevention and Treatment Block Grant (SAPT Block Grant) is to support State and Territorial prevention and treatment services for persons at risk of or abusing drugs and alcohol. The Block Grant accounts for approximately 51% of all public funds expended by the States for substance abuse treatment and prevention. The SAPT Block Grant is allocated to the States by a formula prescribed in the PHS Act, and it provides States the flexibility to plan, carry out and evaluate substance abuse prevention and treatment services provided to individuals and families. Over 10,500 community-based organizations receive SAPT Block Grant funding from the States.

The 5% set-aside supports technical assistance, data collection, and evaluation activities. A portion of these funds is allocated to the development of outcome measures to assist States in monitoring and evaluating substance abuse treatment services.

Performance Partnerships

Implementation of the Children's Health Act of 2000 requires development of a plan for creating flexibility and accountability for States based on a common set of performance measures. In an effort to increase State flexibility and to develop an accountability system based on performance, SAMHSA has been working with the States over the past several years to transition the Block Grant programs into performance partnerships. SAMHSA's reauthorization guidance requires the Secretary to submit to Congress by October 17, 2002, the plan which will outline the flexibility that States will receive under the new partnership and the performance measures that will be used to hold States accountable for their use of federal funds. Once this is accomplished, SAMHSA will be able to document what changes have occurred in access to care, the effectiveness of that care, and how successful the services have been in addressing the needs of vulnerable populations in each of the States and territories. The information gained will help both the State and the Federal government better identify where improvement is needed and the services needed to make those improvements.

The Centers for Substance Abuse Prevention and Treatment have been actively involved with the States in the development of the performance and outcome measures necessary for successful conversion and implementation of performance partnerships. This activity began with agreement

from the States to voluntarily report outcome measures which were included in the SAPT Block Grant Application for the first time for FY 2000. Working through the National Association of State Alcohol and Drug Abuse Directors (NASADAD), a process has begun leading to consensus on a number of measures. To date the process has included:

- Convening three meetings with State representatives to develop consensus based measures. Draft measures were made available to the States for comment and refinement.

- CSAT will be working with the States this year to convene and decide on elements of the plan. These include a task group of State representatives to identify a set of performance measures that addresses the expanded waiver opportunities provided in the statute.

- Through the Treatment Outcomes and Prospective Pilot Studies (TOPPS I and TOPPS II), 19 States have been actively involved in studying the feasibility and practicality of collecting data on these measures. Of major significance has been the development of protocols that will serve as models to the other States as they move to implementation.

Children's Health Act of 2000

The Children's Health Act of 2000 prescribes several important changes to the SAPT Block Grant program guidance as outlined in the Public Health Services Act. Among them are:

- Section 1922(a), under which States were required to spend no less than 35% of their allotment on services regarding alcohol and no less than 35% on services regarding other drugs, has been repealed.

- Section 1925, which required States to maintain a revolving fund of $100,000 to assist with half-way houses for persons recovering from drug or alcohol abuse, is now made optional.

- Section 1930, which requires the States to maintain their financial support for substance abuse services at a level equal to the average of what they had spent the previous two years, is amended to permit non-recurring expenditures for a singular purpose to be excluded from the calculation of the maintenance of effort (MOE) requirement.

- Section 1952 is amended to allow any amount paid to a State for a fiscal year to be available for obligation and expenditure until the end of the fiscal year following the fiscal year for which the amounts were paid. This amendment gives a State <u>two years</u> to spend and obligate its Block Grant allotment.

- Section 1955 is added to permit religious organizations which provide substance abuse services to receive federal assistance either through the SAPT Block Grant (or through SAMHSA discretionary grants) while maintaining their religious character and their ability to hire individuals of the same faith. Also, such programs may not discriminate against anyone interested in treatment at the facility. If a person who is referred for services needs or would prefer to be served in a different facility, the program will refer that person to an appropriate treatment program.

Funding for the Substance Abuse Prevention and Treatment Block Grant program during the last five years has been as follows:

	Funding	FTE
1997	$1,360,107,000	28
1998	1,360,107,000	28
1999	1,585,000,000	28
2000	1,600,000,000	40
2001	1,665,000,000	40

Data Elements Used to Calculate State Allotments

The factors and their data sources used to calculate the FY 2002 SAPT Block Grant allotments are:

- **Total Personal Income** (TPI) - Bureau of Economic Analysis, Department of Commerce; Regional Accounts Data, State Personal Income, 1997-1999, downloaded from BEA web site; source data filename: SA1_5899.PRN, release date 9/12/2000. BEA web site is http://www.bea.doc.gov.

- **Resident Population** - Bureau of the Census, Department of Commerce; Population Estimates for the U.S. and States by Single Year of Age and Sex: July 1, 1999 downloaded from Census web site; source data text file name: ST-99-10.txt, Internet release date 3/9/2000. Census web site is http://www.census.gov/population/www/estimates/st-99-10.html.

- **Total Taxable Resources** (TTR) - Office of Economic Policy, Department of the Treasury; Total Taxable Resources, 1996-1998 provided directly to OAS via e-mail; source data filename: 2000EST.xls, release date 9/29/2000. Data also available on the Treasury web site http://www.treas.gov/ttr.

- **Population data for the territories** based on 1990 Census Data except Micronesia and the Marshall Islands - Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were not included in the 1990 census.

- A **Cost of Services Index Factor**, updated for FY 2001 under a three-year periodic update, includes the following:

- **Fair Market Rents** for the Section 8 Housing Assistance Payments Program — Fiscal Year 2000, downloaded from the HUD web site http://www.huduser.org/datasets/fmr: (a) fmr2000f.dbf, dbase file, released 10/1/99, created 9/23/99 (dbase is the only machine-readable format in which the raw data are offered); (b) fmr2000f.txt, text file, FMR data record layout and file description, released 10/1/99, created 9/27/99; (c) 2000f_pre.doc,

Word file, Federal Register preamble of the FY2000 FMR calculations, released 10/1/99; and (d) fmrover.wp, WordPerfect version of the Federal Register preamble.

Metropolitan Areas, 1999, released by the Office of Management and Budget 6/30/99, filename MSA99.pdf; used by HUD in development of FMR rates. Changes in Metropolitan Areas as Defined by the Office of Management and Budget Since June 30, 1993, filename MAUPDATE.txt, released 6/30/99, Bureau of the Census.

- **1990 Census mean hourly wages** for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1996 hourly hospital wages developed from data collected for the establishment of FY 2000 HCFA Hospital Inpatient Prospective Payment System Wage Rates, collected from the HCFA Internet web site http://www.hcfa.gov/stats/pufiles, publicly available on August 17, 1999. Both executable and zip versions of the data file WAGEDATA.F96 were available on the web site as 1.2 MB self-extracting files which decompressed to a 5 MB fixed length (i.e. "flat") ASCII file consisting of 5,038 records (one record for each unique facility reporting to HCFA); the executable version was downloaded and decompressed. Also downloaded was the file for the data record layout (WDF2000), which was available in several formats. Guidance was also provided by HCFA regarding relevant changes which occurred in reporting format between the FY 1997 and FY 2000 hospital wage data releases.

Primary Prevention

CSAP administers the primary prevention component of the SAPT Block Grant. As required by legislation, 20 percent of Block Grant funds allocated to States must be spent on substance abuse primary prevention services. Prevention services vary significantly in the scope offered at the State and sub-State levels. Some States rely solely on the 20 percent requirement to support their primary prevention activities, others use the funds to target gaps and enhance existing program impact. CSAP's regulations require funds (Federal or other) address the full range of prevention services and activities to ensure each State offers a comprehensive approach to substance abuse prevention.

The SAPT Block Grant supports GPRA Goal 3 (Assure services availability/meet targeted needs), and Goal 1 of the ONDCP National Drug Control Strategy: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco.

Many States are dependent upon the SAPT Block Grant for funding of their Statewide prevention systems. Specific examples of the outcomes from States' use of these funds are:

- The Massachusetts Bureau of Substance Abuse Services has used its SAPT Block Grant funds to support 42 programs throughout the State targeting youth at high risk for substance use/abuse. These program providers were trained to target and implement science-based prevention models using CSAP guidelines for planning and implementing effective programs. They support a wide variety of training and services in such areas as life skills, conflict resolution, peer-to-peer interactions, and resistence skills. Each program has been tested and validated for its success in addressing the needs of high risk youth and for its replicability in

a wide range of settings. Children between the ages of 12 and 17 throughout the State are selected to participate in these programs.

- The State of Pennsylvania has developed a state-wide system to collect, disseminate and educate its citizens on substance abuse issues. This clearinghouse of information makes available to the general public and to professionals in the prevention field information and materials that have been proven effective. Examples of information that the State provides are films, pamphlets, educational materials, and other media specifically assisting educators and others in their efforts to prevent substance abuse.

- The State of Ohio has used a portion of its SAPT Block Grant prevention resources to develop a state-wide effort to prevent binge drinking on college and university campuses. The State brought together representatives from its major colleges and universities to discuss and develop effective programs and services for college-age students. Examples of activities implemented include alternatives to parties where binge drinking might take place, changing school alcohol policies, working with student organizations to communicate the dangers of binge drinking and soliciting their assistance, and supporting an infrastructure for targeting and addressing alcohol abuse and its related problems.

- States have demonstrated marked success in reducing the rate at which retailers sell tobacco products to minors, as required under the Block Grant's Synar Amendment. Enacted in 1992, it requires that State have and enforce laws that restrict minors' access to tobacco products. Each State has negotiated annual targets for reducing retailer sales, and the law specifies penalties for failure to reach these targets. Since FY 1997 (i.e., surveys conducted in FY1996), States have reduced retailer violation rates from 40.1 percent to 20.3 percent (as reported in FY 2000). Twenty-five States reported noncompliance rates at or below 20 percent. Six States reported noncompliance rates of under 10 percent. All States have plans in place to ensure their noncompliance rate is 20 percent or less by FY 2003. In FY 2000, CSAP provided technical assistance to 32 States and 3 jurisdictions to support implementating programs and strategies to help prevent youth access to tobacco products.

Rationale for the Budget Request . . . . . .

The FY 2002 request includes a $60 million increase for the SAPT Block Grant, for a total program level of $1.725 billion. This $60 million is part of $100 million requested for SAMHSA as part of the President's Drug Treatment Initiative which will increase access to drug treatment services and narrow the treatment gap. Providing States and Territories with larger SAPT Block Grant allocations will increase prevention and treatment services and will advance the goal of reducing the treatment gap. The total number of persons being provided treatment services with federal SAPT Block Grant funding in FY 2002 is expected to increase by approximately 4,800 for a new total of approximately 342,000 persons served (an increase of 1.4%).

Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention and Treatment Block Grant

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate		Increase
Alabama	$22,197,312	$22,994,659	$23,828,000	+	$833,341
Alaska	3,440,623	3,859,949	4,277,240	+	417,292
Arizona	27,127,147	27,464,922	28,117,057	+	652,135
Arkansas	11,335,103	12,030,024	12,331,662	+	301,638
California	223,282,608	235,159,291	250,563,304	+	15,404,013
Colorado	20,297,398	21,382,601	22,213,303	+	830,702
Connecticut	16,405,660	16,609,936	16,793,393	+	183,457
Delaware	5,553,544	6,230,383	6,468,750	+	238,367
District Of Columbia	4,952,603	5,556,201	6,156,871	+	600,670
Florida	81,263,908	86,669,748	90,044,401	+	3,374,653
Georgia	41,396,779	44,792,764	46,420,319	+	1,627,554
Hawaii	6,983,864	7,070,824	7,164,579	+	93,755
Idaho	5,943,750	6,329,272	6,752,451	+	423,179
Illinois	61,204,360	65,196,054	67,579,749	+	2,383,695
Indiana	32,509,147	32,913,937	33,277,473	+	363,536
Iowa	12,542,219	12,698,390	12,838,644	+	140,254
Kansas	11,060,004	11,699,847	12,280,272	+	580,426
Kentucky	19,276,066	19,841,212	20,646,000	+	804,788
Louisiana	24,828,318	25,137,470	25,826,897	+	689,428
Maine	5,943,750	6,243,750	6,468,750	+	225,000
Maryland	29,389,161	31,079,266	31,950,492	+	871,227
Massachusetts	33,214,336	33,627,906	33,999,328	+	371,422
Michigan	56,510,128	57,213,767	57,845,696	+	631,929
Minnesota	20,877,637	21,137,596	21,672,297	+	534,701
Red Lake Indians	514,557	520,964	534,143	+	13,178
Mississippi	13,183,451	13,610,335	14,067,607	+	457,272
Missouri	24,223,136	25,157,268	26,134,320	+	977,052
Montana	5,584,314	6,243,750	6,468,750	+	225,000
Nebraska	7,472,914	7,689,486	7,885,645	+	196,159
Nevada	9,619,717	10,767,511	11,290,684	+	523,172
New Hampshire	5,943,750	6,243,750	6,468,750	+	225,000
New Jersey	45,115,909	45,941,123	46,898,148	+	957,025
New Mexico	8,261,541	8,364,410	8,570,852	+	206,442
New York	104,711,026	108,498,257	111,896,957	+	3,398,701
North Carolina	33,680,936	34,472,623	35,377,284	+	904,662

Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention and Treatment Block Grant

State or Territory	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate		Increase
North Dakota	3,817,151	4,282,367	4,745,325	+	462,959
Ohio	65,062,211	65,872,337	66,599,900	+	727,563
Oklahoma	16,559,798	17,257,097	17,697,861	+	440,764
Oregon	15,268,109	15,477,533	15,844,227	+	366,693
Pennsylvania	57,670,348	58,388,433	59,033,336	+	644,903
Rhode Island	5,943,750	6,243,750	6,468,750	+	225,000
South Carolina	18,663,663	19,670,678	20,555,962	+	885,283
South Dakota	3,529,799	3,959,993	4,388,101	+	428,107
Tennessee	25,999,363	28,299,310	29,240,906	+	941,596
Texas	124,118,032	127,289,421	132,649,226	+	5,359,805
Utah	14,551,928	15,791,123	16,460,288	+	669,165
Vermont	3,774,105	4,234,075	4,691,812	+	457,738
Virginia	39,245,298	40,929,104	42,309,094	+	1,379,991
Washington	31,732,096	33,750,255	34,946,027	+	1,195,772
West Virginia	8,434,819	8,539,845	8,634,168	+	94,323
Wisconsin	24,530,479	24,837,927	25,745,004	+	907,077
Wyoming	2,452,377	2,751,260	3,048,693	+	297,434
State Sub-total	**$1,497,200,000**	**$1,558,023,750**	**$1,614,168,750**	+	**$56,145,000**
American Samoa	265,751	276,547	286,512	+	9,966
Guam	756,531	787,265	815,635	+	28,370
Northern Marianas	246,274	256,279	265,514	+	9,235
Puerto Rico	20,011,195	20,824,150	21,574,569	+	750,420
Palau	85,919	89,409	92,631	+	3,222
Marshall Islands	254,171	264,497	274,028	+	9,531
Micronesia	601,710	626,155	648,719	+	22,564
Virgin Islands	578,449	601,949	623,641	+	21,692
Territory Sub-total	**$22,800,000**	**$23,726,250**	**$24,581,250**	+	**$855,000**
Federal Set-Aside	**80,000,000**	**83,250,000**	**86,250,000**	+	**3,000,000**
GRAND TOTAL	**$1,600,000,000**	**$1,665,000,000**	**$1,725,000,000**	+	**$60,000,000**

SUBSTANCE ABUSE BLOCK GRANT (SET-ASIDE)

Authorizing Legislation - Section 1935 of the Public Health Service Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
BA (non-add)	($80,000,000)	($83,250,000)	($83,250,000)	(+$3,250,000)	($86,250,000)	(+$3,000,000)

2002 Authorization $86,250,000

Purpose and Method of Operation .....

The 5% set-aside of the Substance Abuse Prevention and Treatment Block Grant (SAPT Block Grant) supports data collection, technical assistance, and program evaluation activities throughout the Agency. SAMHSA is the major source of information in the United States on the extent and nature of substance abuse, the supply and cost of services for treating substance abuse, and the number and characteristics of persons in treatment. Much of this information is produced by data systems developed and managed by the Office of Applied Studies (OAS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). These data are used by the Department of Health and Human Services, the Office of National Drug Control Policy, the Drug Enforcement Agency, and State and local agencies to plan and evaluate programs to address health and associated social problems.

Office Applied Studies (OAS)

The authorizing legislation of SAMHSA requires the annual collection of data on the national incidence and prevalence of substance abuse, emergency room admissions due to a substance abuse problem, and the characteristics and costs of treatment facilities and the number and characteristics of individuals in treatment. These data are obtained in three major surveys: (1) the National Household Survey on Drug Abuse (NHSDA); (2) the Drug Abuse Warning System (DAWN); and (3) the Drug and Alcohol Services Information System (DASIS). These surveys are the only source of national data on the extent of substance abuse in the general population and the nature of the treatment system. They also provide information critical to evaluating the success of Federal and State substance abuse programs.

National Household Survey on Drug Abuse. Since it began in 1971 the NHSDA has been the primary source of information on the prevalence and incidence of substance abuse in the general, non-institutionalized population. Information provided by the NHSDA is used to study trends in the use of licit and illicit drugs, changing attitudes about substance use, the demand for treatment programs, and factors associated with the initiation of substance use and abuse.

Beginning with the 1999 NHSDA, the sample was expanded from 18,000 to 70,000 respondents. This new sample makes it possible to estimate substance use in the individual States. Based on separate

samples of roughly 3900 respondents, substance use can be estimated directly for the eight largest States, which together account for more than 50% of the population. Estimates for each of the other 42 States and the District of Columbia are based on a model that takes into account information obtained from 900 respondents in each State. Because of the nature of the sample and the identical survey questionnaires and methods for every State, SAMHSA and its data users can for the first time compare States with respect to prevalence rates and trends. These State estimates provide information that can be used to help direct Federal funds to areas with severe or unique problems.

There are other benefits associated with the increase in the NHSDA sample. The survey now includes 25,000 youth between 12 and 17 years of age, a sample size improving the precision of the estimates for this age group. Because of sample design and size, the NHSDA may now be the best source of information for this age group on substance use and attitudes. The sample also contains a large number of respondents over the age of 55 years making possible some studies of substance abuse in a population that has not received sufficient attention. The sample now allows for separate, national estimates for minority groups, such as Chinese or Japanese Americans, that could not be captured with a smaller sample.

There are other important changes in the survey as well. The special module for measuring the use of tobacco products introduced in 1999 will provide very precise estimates of trends in use by youth over time. The 2001 NHSDA is collecting information on mental illness in children to better understand the extent and nature of the co-occurrence of mental and substance abuse problems.

In FY 2001 NHSDA questions will be added to determine the extent of serious mental illness in adults and the relationship of this problem with substance abuse. Information on the use, cost, and source of payment for mental health services for both youth and adults has been collected since 2000. Finally, the NHSDA is now being conducted using a computer; answers to the most sensitive questions are entered directly into the computer by respondents. Studies of this technology indicate respondents believe it increases privacy and encourages them to be more truthful in providing answers.

Drug Abuse Warning Network. DAWN collects information on admissions to emergency departments of hospitals or cases seen by medical examiners that are caused by or associated with the use of illicit or licit drugs. The information in DAWN is drawn from medical records. DAWN was developed in the early 1970s by the Drug Enforcement Administration (DEA). Although SAMHSA now supports and manages DAWN and uses DAWN data to track changes in drug abuse problems, the data are still used by DEA for surveillance and resource allocation. They are also used by the Food and Drug Administration (FDA) to identify problems with licit drugs that can not be detected with the limited samples employed in clinical trials.

The Office of Applied Studies is conducting a series of studies to determine the most effective sampling and data collection strategy for DAWN. These studies are prompted by the changes in the health care system which may also affect the use of emergency departments in hospitals, by the need for more extensive information on drug related admissions, and by the demand for more timely information. The studies have prompted the development of a new drug dictionary and experimentation with new communication technologies. The Agency expects to have the changes in place to accelerate the delivery and analysis of DAWN information by 2002.

Drug and Alcohol Services Information System. DASIS is the only source of national data on services available for substance abuse treatment and the characteristics of individuals admitted for treatment. DASIS consists of three data sets: (1) the National Facility Register (NFR), which lists all facilities in the country which are recognized by States; (2) the Uniform Facility Data Set (UFDS), which contains information on the services, and resources of treatment facilities in the country including those not recognized by States; and (3) the Treatment Episode Data Set (TEDS), which contains information on every patient admitted to a facility receiving public funds. These data sets are assembled and maintained with support from various State agencies.

Information in the NFR provides the basis for a new Treatment Facility Locator System now available to the public on the Web. The information in this new system is updated monthly. The locator permits individuals seeking substance abuse treatment to find a facility in their area providing the type of treatment and services they seek. Street maps indicate the exact location of the facility and travel routes; accompanying text describes the services available and other information, such as type of payment accepted.

TEDS data reveal that recent increases in admissions to facilities are principally the result of an increase in admissions of those aged 12-17 years.

Using data now available from TEDS, it is possible to graphically present variations among States with respect to drugs being abused and the characteristics of those being admitted for treatment. Such analyses have added a new dimension to our ability to track substance abuse problems, the appearance of new drugs, and changing patterns of use.

In addition, OAS conducts studies evaluating the effectiveness of substance abuse treatment and the validity of the information obtained from providers. The largest of these studies, the Alcohol and Drug Services Survey (ADSS), is directed by a team of investigators at Brandeis University. Among other things, ADSS was designed to describe the changes occurring in the organization and structure of the substance abuse treatment system, and to assess the impact of these changes on the process and effectiveness of treatment.

Center for Substance Abuse Prevention (CSAP)

CSAP supports a comprehensive and integrated approach to improving substance abuse prevention services delivered by States. CSAP uses set-aside funding to improve State prevention systems, including development and implementation of advanced prevention methodology for all components of State prevention systems, such as data collection and performance measurement. These resources help provide policy and program guidance to report use of the Block Grant prevention funds. Specific examples of activities to be continued in FY 2002 include:

State Needs Assessments

CSAP's State Needs Assessment Program has awarded 3-year contracts to 27 States over the past four years. The purpose of the program is to assist States focus their prevention programming, resource allocation, and performance measurement on scientifically sound, quantitative data, and to help improve the States' capacity and infrastructure to conduct studies and report performance. States receiving contracts are required to conduct a core set of studies, including school-based and community resource assessments. This information is especially useful to those States which have received a State Incentive Grant, as they begin to implement science-based prevention programs addressing their identified critical capacity needs. The information has also been invaluable to CSAP in establishing targeted capacity prevention programs and emphasis.

Prevention Technical Assistance (TA) to States

CSAP has provided TA activities to all States and U.S. jurisdictions to support their substance abuse prevention systems. TA has been provided on-site, by phone, and in multi-State formats. Primary areas of assistance provided include: general TA (addressing prevention system infrastructure); youth tobacco control (helping States to develop tools and strategies to comply with the Synar regulation); minimum data sets (promoting common data collection regarding service characteristics and populations served with a set of defined data elements); and State Incentive Grant support.

Technical assistance provided during past six months, in addition to responding to requests, includes:

- Completed one multi-state event in Orlando, Florida, with representatives from more than a dozen States.

- Provided two training events on technical assistance processes and procedures for more than 100 prevention and tobacco use consultants from across the country.

- Conducted the Fifth National Synar Workshop with more than 200 attendees representing 55 States/Jurisdictions and Federal partners. The theme of this year's workshop was "Providing Leadership. Making a Difference".

- Completed six on-site reviews/assessments of State prevention and Synar systems (South Carolina, Mississippi, Wyoming, Delaware, Pennsylvania, and Iowa) and developed technical assistance work plans for each State. At least 25 visits will be conducted throughout the remainder of the fiscal year.

- Developed a site visit review guide and site visit report format for Synar site visits.

- Developed three guidance documents (Synar sampling designs, guidance for completing the prevention portion of the SAPT Block Grant application, and guidance for completing the Synar portion of the SAPT Block Grant application).

Minimum Data Set Program

The CSAP Minimum Data Set (MDS) Program makes an economical, efficient, and user-friendly database management information system (MIS) available to State, sub-State, and local substance abuse prevention agencies and prevention service providers. The common data sets and definitions were developed through a consensus process with State officials and CSAP. The MIS is a PC-based software package for capturing, organizing, and reporting information on the populations served and substance abuse prevention services provided. The MIS is used on a voluntary basis to collect uniform information in the areas of prevention programming, resource allocation, process evaluation, measuring performance, and data sharing.

Center for Substance Abuse Treatment (CSAT)

CSAT responds to specific requests from State and Territorial substance abuse directors for technical assistance and training to enhance their jurisdictions' capacity to deliver effective treatment services, or to better manage relevant data in order to monitor outcomes. Some examples of projects funded by CSAT's allocation of the SAMHSA set-aside are:

Percentage of Technical Assistance events that result in systems, program, or practice change:

FY99 - 66%
FY00 - 84%
FY01 - 85%

Technical Assistance

- A **Colorado** workshop on delivery of services to pregnant and parenting women in rural areas;
- TA and training events designed to enhance the cultural appropriateness of services in **Michigan, New Mexico, Oklahoma**, and **South Dakota**.
- Training in **Arizona** and **Michigan** on services for clients with co-occurring mental and addictive disorders.
- Training in **Kentucky** and **Vermont** to enhance services for substance abusing criminal and juvenile offenders.
- TA to help **Puerto Rico** and **New Jersey** develop service delivery strategic plans.

Confidentiality Training. CSAT also sponsors confidentiality training through the SAPT Block Grant Set-aside. Sessions conducted during FY 2001 included:

- **Kentucky**. The focus of the training was on collaboration across systems with an emphasis on joint planning and increasing the information other systems have about substance abuse regulations. There were 122 participants including staff from the district courts working with substance abuse clients, TANF officials, Transportation, DUI programs and the Office of Court Administration.

- **Maine**. The focus of the training was on criminal justice system collaboration. There were 50 participants from the juvenile drug treatment courts from around the State.

CSAT's Block Grant set-aside resources also are used to support the State Treatment Needs Assessment Program (STNAP), which assists the States in program planning and rational allocation of Block Grant funds received. The STNAP program has been responsible for production of over 350 study reports (with about 100 more expected), which have been distributed to the substance abuse treatment community. STNAP data from these reports have been utilized by county policymakers and State officials for sub-State planning and resource allocation in many States. Some examples of utilization of STNAP data are:

- In **Illinois**, STNAP data are used in the review of "need" versus "capacity" in each of the 20 Illinois Substance Abuse Service Networks, resulting in capacity expansion being targeted to areas identified as having the largest gaps between need and services. In FY 2001, this was the basis of an expansion of services for youth, adult transitional centers, and for expansion of services to men (non-criminal justice, working poor).

- The **New Jersey** Commissioner of Health and Senior Services convened a Statewide Substance Abuse Advisory Task Force in July 2000 to develop a State plan to guide the development of addiction treatment services. The task force planning document draws heavily on data from New Jersey's needs assessment studies and includes an extensive, needs assessment-based treatment capacity/demand analysis.

- **New York** conducted a family of studies including a Statewide household survey. The data produced have been used as the basis for prevalence estimates in a wide variety of the Single State Agency's activities. These include: estimates for both adults and youth used in the Block Grant Application; county prevalence estimates that are returned to local service providers around the State to assess their needs; regional reports about youth that were disseminated in regional forums statewide and which were used to develop educational curricula and prevention services; and estimates for both youth and adults that were shared with providers and researchers throughout the State.

- The **New Mexico** Department of Health has used data generated by its STNAP-supported Substance Use Among Childbearing Age Females (SUCAF) study to institute substance abuse recognition and counseling training in its public health offices.

- **Minnesota** is using its integrated needs assessment and treatment utilization data bases to establish baselines for access to substance abuse treatment that will then allow the State to monitor changes in availability and access as managed care substance abuse treatment programs are introduced.

National Treatment Outcomes Monitoring System (NTOMS)

The Center for Substance Abuse Treatment, in collaboration with the SAMHSA Office of Applied Studies, is proposing to develop, implement, and operate a National Treatment Outcomes Monitoring System (NTOMS) in support of the National Drug Control Strategy as well as Departmental and

Agency goals. This effort will require the involvement of a number of other Departments, including the Department of Veterans Affairs and the Department of Justice, in order to assess the effectiveness of substance abuse treatment regardless of the setting in which it occurs.

Outcomes monitoring involves assessment of participants' functioning before, during, and following a specific treatment episode, without specifically evaluating the effectiveness of the particular treatment program relative to some other program. Outcomes monitoring is used by policymakers such as Federal and State government agencies, and insurers to hold treatment programs accountable for their activities in a normative way. Outcomes monitoring is also useful to the programs themselves for self-monitoring. Self-monitoring allows providers to collect reliable and up-to-date information about patient and program characteristics and the frequency and effectiveness of services delivered. This information is necessary to accurately describe patient flow and service delivery patterns and to examine outcomes that the program can use to refine admission criteria, clinical protocols, and service intensities.

Work on the components of NTOMS began in 1996 by the Office of National Drug Control Policy (ONDCP). The principal component, and the one that is most developed at the current time, is the Drug Evaluation Network System (DENS). The goal of the DENS project is to develop a network of sentinel substance abuse treatment programs that provide functional, clinical, and administrative data on persons presenting for admission to substance abuse treatment programs. DENS utilizes portions of the Addiction Severity Index to provide information on the nature and severity of family, medical, psychiatric, employment, legal, alcohol and drug problems.

CSAT has been providing resources to (1) refine the software that is used to create the reporting and transmission mechanisms, to carry out the necessary analyses, and to develop the feedback reports that will become the infrastructure for NTOMS; and (2) initiate the advisory board called for in the NTOMS implementation plan. The current plan includes constructing a representative sample of programs in eight cities and collecting admission information on samples of clients in those programs.

NTOMS will provide the means for SAMHSA to assess substance abuse treatment outcomes on a national level. It will become a source for data on the nature and extent of substance abuse in the population seeking treatment, and it will provide a means for measuring progress in the treatment of one of the most significant chronic disease problems facing this country.

It is anticipated that NTOMS will become the outcome measurement standard for all Federal and other publicly-funded substance abuse treatment systems. In the outyears, program refinement and expansion would mirror progress and direction as reflected by overall trends in the substance abuse problem nationwide.

CSAT will allocate $5 million in set-aside resources in FY 2001 to continue development of NTOMS. Approximately $10 million will be required in FY 2002.

PROGRAM MANAGEMENT

Authorizing Legislation - Section 301 of the Public Health Service Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
PM	$59,049,000	$79,221,000	$79,173,000	+$20,124,000	$67,173,000	-$12,000,000
FTE	541	560	560	+19	560	—
(Program Mgmt)	(488)	(507)	(507)	(+19)	(507)	—
2002 Authorization						Indefinite

Purpose and Method of Operation

The Program Management activity supports the majority of the staff who plan, direct, and administer SAMHSA programs, and who provide technical assistance and program guidance to States, mental health and substance abuse professionals, clients, and the general public regarding the Agency's programs. As such, it represents a critical component of SAMHSA's budget request. Agency staff not included in this activity provide State technical assistance and are funded through the Block Grant set-asides.

SAMHSA continues to play a key role in the mental health and substance abuse fields by initiating new programs and providing national leadership in all aspects of behavioral health. Recent increases emphasize the HIV/AIDS program, expanded treatment services, and collection of national data.

Future activities will include:

- Developing a performance partnership approach to working with States in supporting services through Block Grants;
- Improving State and federal data collection and analysis in order to enhance program outcome reporting;
- Increasing consultations with Indian Tribes and other organizations with respect to SAMHSA program priorities;
- Continuing to implement new program authorities included in the recent reauthorization;
- Continuing development of the opioid accreditation program.

These activities, as well as increased reliance on cooperative agreement funding mechanisms, have required more intensive staff involvement to monitor programs while ensuring accountability and results. Evaluation activities have increased substantially, as have the collection of data required by GPRA legislation.

Funding and staffing levels for all SAMHSA programs for the past five fiscal years were as follows:

	Funding	FTE
1997	$55,331,000	552
1998	55,400,000	549
1999	56,517,000	563
2000	59,054,000	541
2001	79,173,000 *	560

* Includes $12,000,000 added to support National Data Collection.

Rationale for the Budget Request . . . . . .

The FY 2002 Program Management reduction of $12 million represents a change in financing source for a portion of the Household Survey on Drug Abuse (NHSDA). The Department's one percent evaluation funding. These funds are provided under Sec. 241 of the PHS Act, and will be transferred to SAMHSA from other sources.

The 2002 request includes the same total FTE level for SAMHSA as in FY 2001. Funds necessary to support mandatory cost increases, primarily for pay, will be derived from savings achieved by ending a one-year congressional earmark funded at the level of $3.3 million in FY 2001.

The need to implement new and growing program responsibilities while effectively monitoring programs and outcomes has required SAMHSA to review and prioritize agency responsibilities. A Workforce Planning project has been initiated to gather data to determine future agency staffing needs and how best to meet them. Staff competencies and future program requirements have been identified. The SAMHSA Workforce Planning model being developed will consider:

- Anticipated future program growth and directions
- Major staff responsibilities and activities
- Internal workflow analysis
- Currently available staff and contractor competencies
- Projected unmet staffing needs, and how best to address them

The review is expected to provide a blueprint for future hiring needs, recruitment strategies, and opportunities to employ best management practices. Staff shortages which may exist might, in part, be addressed through the redirection of staff or changes in internal work processes.

Full-Time Equivalent (FTE) Employment

	FY 2000 Actual	FY 2001 Estimate	FY 2002 Estimate	Increase or Decrease
Program Management:				
Direct	486	505	505	—
Reimbursable	2	2	2	—
Sub-total	488	507	507	---
Block Grant Set-Aside	53	53	53	—
Sub-total	541	560	560	---
Reimbursable Exempt				
District of Columbia/ St. Elizabeths Hospital	70	72	72	—
TOTAL SAMHSA	611	632	632	---

Increases:

Built-in:

Annualization of 2001 pay raise (3.7%)	+$464,000
Within grade pay increases	+903,000
Increase for January 2002 pay raise at 3.6%	+1,355,000
Increase in rental payments to GSA	+209,000
One additional day pay	+192,000
Increased cost of overhead charges	+524,000
Subtotal, Built-in	+3,647,000
Total, increases	+3,647,000

Reductions:

Built In:

Non-recurring costs of one-year congressional earmark project	-3,278,000

Program:

Reductions in operating costs	-369,000
Total, reductions	-3,647,000
Net Change	---

Substance Abuse and Mental Health Services Administration
Detail of Full-Time Equivalent Employment (FTE)

	2000 Actual	2001 Estimate	2002 Estimate
Center for Mental Health Services	116	128	125
Center for Substance Abuse Prevention	117	116	117
Center for Substance Abuse Treatment	116	122	121
Office of Applied Studies	29	29	30
Office of Program Services	91	97	96
Office of the Administrator	72	68	71
Total, SAMHSA	541	560	560

Average GS Grade
- 1996.....11.04
- 1997.....11.04
- 1998.....11.70
- 1999.....11.67
- 2000.....11.67
- 2001.....11.67
- 2002.....11.90

Substance Abuse and Mental Health Services Administration
Detail of Positions

	2000 Actual	2001 Estimate	2002 Estimate
Executive Level I	---	---	---
Executive Level II	---	---	---
Executive Level III	---	---	---
Executive Level IV	1	1	1
Executive Level V	---	---	---
Subtotal	1	1	1
ES-6	2	2	2
ES-5	2	2	2
ES-4	3	3	3
ES-3	1	1	1
ES-2	---	---	1
ES-1	2	2	1
Subtotal	10	10	10
GM/GS-15	67	68	68
GM/GS-14	118	116	116
GM/GS-13	157	158	158
GS-12	32	38	38
GS-11	11	11	11
GS-10	3	3	3
GS-9	23	24	24
GS-8	21	22	22
GS-7	42	41	41
GS-6	13	17	17
GS-5	6	8	8
GS-4	5	6	6
GS-3	---	1	1
GS-2	---	2	2
GS-1	1	1	1
Subtotal	499	516	516
CC-08/09	---	---	---
CC-07	1	2	2
CC-06	21	21	21
CC-05	4	4	4
CC-04	4	5	5
CC-03	0	0	0
CC-02	1	1	1
CC-01	---	---	---
Subtotal	31	33	33
TOTAL Full-Time Equivalent	541	560	560
Full-Time Equivalent Usage	611	630	630
Average GS Grade	11.67	11.67	11.90

DRUG ABUSE BUDGET
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

I. RESOURCE SUMMARY

(Budget Authority in Millions)

	2000 Final	2001 Enacted	2002 Request
Drug Resources by Goal			
Goal 1	$434.8	$483.7	$511.6
Goal 3	1,090.3	1,171.6	1,243.3
Total	$1,525.1	$1,655.3	$1,754.9
Drug Resources by Function			
Prevention	$434.8	$483.7	$511.6
Treatment	1,090.3	1,171.6	1,243.3
Total	$1,525.1	$1,655.3	$1,754.9
Drug Resources by Decision Unit			
Programs of Regional & National Significance 1/	$361.1	$431.1	$471.1
Prevention (Non-add)	*(146.7)*	*(175.0)*	*(175.0)*
Treatment (Non-add)	*(214.4)*	*(256.1)*	*(296.1)*
Substance Abuse Block Grant	$1,137.1	$1,183.3	$1,226.0
Prevention (Non-add)	*(220.9)*	*(230.7)*	*(241.6)*
Treatment (Non-add)	*(864.5)*	*(902.9)*	*(934.6)*
Office of Applied Studies (Non-add)	*(51.7)*	*(49.7)*	*(49.7)*
Program Management	$26.9	$40.9	$28.8
Prevention (Non-add)	*(12.8)*	*(13.6)*	*(13.6)*
Treatment (Non-add)	*(11.4)*	*(12.6)*	*(12.6)*
Office of Applied Studies (Non-add) 2/	*(2.7)*	*(14.7)*	*(2.7)*
Total, BA	$1,525.1	$1,655.3	$1,725.9
Data Collection (1% Evaluation) 3/	---	---	$29.0
Total, Program Level	$1,525.1	$1,655.3	$1,754.9
Drug Resources Personnel Summary			
Total FTEs (direct only)	312	312	312
Information			
Total SAMHSA Budget, Program Level	$2,651.3	$2,957.4	$3,058.5
Drug Percentage	57.5%	56.0%	57.4%

Footnotes:

1/ This table has been structured to reflect the new budget line Programs of Regional and National Significance (PRNS), consistent with SAMHSA's Re-authorization (Children's Health Act of 2000, Part B) and Conference Report 106-1033, Making Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 2001.

2/ OAS Program Management includes an earmarked allocation of $12.0 million for the National Household Survey on Drug Abuse (NHSDA) in FY 2001.

3/ The Data Collection line reflects proposed reimbursements with funds from DHHS 1% evaluation in FY 2002.

II. METHODOLOGY

- All funding for SAMHSA's Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) Programs of Regional and National Significance activities is considered to be 100% drug-related, and is included in its entirety.

- Funding for the SAPT Block Grant, which is administered by the CSAT, is considered drug-related to the extent that these funds are used by the States/Territories for prevention and treatment of the use of illegal drugs, prevention and treatment of alcohol-related drug use, including underage alcohol use, and as used by SAMHSA for technical assistance, data collection, and program evaluation. SAMHSA employs a methodology to estimate drug related expenses funded by the SAPT Block Grant that is consistent with the earmarks required by Public Law 102-321, the ADAMHA Reorganization Act, and which results in scoring of 71.07% of the SAPT Block Grant for drug and drug-related activities. The Children's Health Act of 2000, P. L.106-310, October 17, 2000, makes significant changes in funding policy for the SAPT Block Grant. However, estimations continue to be based on the previous requirements at this time.

- All funding for SAMHSA's Office of Applied Studies (OAS) substance abuse surveys/data collection activities funded by the SAPT Block Grant set-aside, is considered to be 100% drug-related, and is included in its entirety.

- Funding for Program Management activities is considered drug-related to the extent that funds are used to support the operations of the CSAP, CSAT, and OAS. Estimates are based on total Program Management budget authority and reflect allocation of program management funds to these components, as documented in internal SAMHSA financial records.

- All reimbursements for SAMHSA's Office of Applied Studies (OAS) substance abuse surveys/data collection activities funded under Data Collection (1% evaluation) is considered to be 100% drug-related, and is included in its entirety.

III. PROGRAM SUMMARY

SAMHSA supports the goals of the National Drug Control Strategy, identified below, through a broad range of programs focusing on prevention and treatment of the abuse of illicit drugs. Primary goals are to close the gap between available treatment capacity and demand, to link knowledge gained from research with prevention and treatment practices, and to improve and strengthen national efforts employed by communities, State and local governments, and provider organizations and systems in the national effort to prevent illicit drug use and provide high quality science-based treatment for those who are in need.

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

Financial support for this goal includes funding for prevention Programs of Regional and National Significance (PRNS), data collection activities (administered by OAS), and 20% of SAPT Block Grant, as well as Program Management support for these activities.

– CSAP's prevention programs involve developing and assessing new and emerging prevention methodologies and approaches; collecting, analyzing, and synthesizing prevention outcome knowledge, and monitoring national trends in substance abuse and emerging issues. After field testing promising approaches in knowledge development programs, emphasis shifts to the synthesis and dissemination of the knowledge gained from these final study phases to the practical application of these strategies by States and local communities. Knowledge application programs help substance abuse prevention practitioners and policy makers in States and communities systematically deliver and apply skills, techniques, models, and approaches to improve substance abuse prevention services.

– CSAP's State Incentive Grants (SIGs) are designed to address the specific and immediate prevention service capacity needs within the States and communities. SIG grants represent a comprehensive effort to improve the quality and availability of effective research-based prevention services and help States and communities address and close gaps in prevention services which often cannot be addressed via Block Grant funding.

– Other CSAP prevention activities support testing of a wide variety of interventions to prevent substance abuse among children and youth, focusing in particular on youth who are at high risk for becoming substance abusers and/or involved in the juvenile justice system. In addition, prevention funding also supports limited, but targeted, services in discrete areas of unmet or emerging local needs made apparent from epidemiological data, from local experience, or created as a result of local, State or national social policy change.

– SAPT Block Grant activities include State expenditures of 20% of their Block Grant allotment for primary prevention services as well as at least 20% of the Block Grant set-aside. The latter supports the collection and analysis of national data, the development of State data systems (including the development and maintenance of baseline data on the incidence and prevalence as well as the development of outcome measures on the effectiveness of prevention programs), provision of technical assistance, and program evaluations. Also, this program supports oversight of Synar Amendment implementation requiring States to enact and enforce laws prohibiting the sale and distribution of tobacco products to persons under 18 so as to reduce the availability of tobacco products to minors.

Goal 3: Reduce health and social costs to the public of illegal drug use.

Financial support for this goal includes funding for treatment Programs of Regional and National Significance (PRNS) and 80% of the SAPT Block Grant, as well as Program Management support for these activities.

– CSAT's funding for treatment programs includes activities to bridge the gap between knowledge and practice, promote the adoption of best practices, and assure services availability/meet targeted needs. These treatment programs support knowledge development and testing of new and innovative treatment approaches and are used to disseminate information on those systems shown to be most effective. These resources also support a network of regionally-based curriculum developers, trainers, and consultants that is sensitive to the particular cultural and treatment needs of the people in that region, and provides services ranging from traditional training activities through on-site assistance and mentoring.

– CSAT's treatment service programs focus on reducing the substance abuse treatment gap by supporting rapid and strategic responses to demands for services. The response to treatment capacity problems may include communities with serious, emerging drug problems or communities struggling with unmet need. These programs can be general in nature, serving a wide range of critical populations, such as adolescents, young adults, women and their children, persons involved with the criminal justice system, and ethnic and racial minorities. Since FY 1999, CSAT's targeted services programs have also included an HIV/AIDS component targeting minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS. A special homeless component will be added in FY 2001.

– SAPT Block Grant activities include State expenditures of 80% of their Block Grant allotment for treatment services (including up to 5% for State administration), as well as CSAT and OAS expenditures of approximately 80% of the Block Grant set-aside for the collection and analysis of national data, the development of State data systems (including the development and maintenance of baseline data on the incidence and prevalence as well as the development of outcome measures on the effectiveness of treatment programs), provision of technical assistance, and program evaluations.

– CSAP provides oversight for the Federal Drug Free Workplace Program, which addresses reduction of adult substance abuse demand in the Federal service and promulgates scientific and technical guidelines for Federal employee drug testing programs, and for the National Laboratory Certification Program (NLCP). The latter certifies drug testing laboratories, provides guidance for self-sustaining drug testing programs, and is the federal focal point for developing and implementing non-military, federal workplace drug testing technical, administrative and quality assurance programs.

IV. BUDGET SUMMARY

2001 Program

The total drug control budget supported by the 2001 appropriation is $1.655 billion, including $483.7 million for Goal 1 activities and $1.171 billion for Goal 3 activities.

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

A total of $230.7 million (including $10.7 million in prevention set-aside funding) is available for Goal 1 primary prevention activities from the Substance Abuse Prevention and Treatment Block Grant. Activities funded through the Block Grant prevention funds include:

- supporting prevention technical assistance to the States in areas of implementing science-based prevention services, prevention workforce development, strategic planning and other elements critical to the States' overall prevention systems;

- assisting the States in the effective implementation of Synar (youth access to tobacco products) compliance;

- providing support to the States in developing and/or enhancing their prevention data infrastructure, including design and implementation of needs assessments; and

- measuring the effectiveness of prevention activities funded through the SAPT Block Grant.

A total of $175.0 million is available for Goal 1 prevention Programs of Regional and National Significance, as follows:

- Community Initiated Prevention Intervention Program. This program tests effective substance abuse prevention interventions that have been shown to prevent or reduce alcohol, tobacco, or other illegal drug use as well as associated social, emotional, behavioral, cognitive and physical problems among at-risk populations in their local communities. The program is determining the most effective prevention intervention models and associated services for preventing, delaying and/or reducing substance use and abuse by at-risk populations and measuring and documenting reductions in substance abuse and associated problems as compared to comparison groups. In FY 2001, this program will focus on several emerging issues in substance abuse prevention: fetal alcohol syndrome/alcohol related birth defect; children of substance abusing parents; methamphetamine, ecstacy, or club drugs; underage or binge drinking; workplace substance abuse; and drug misuse among the elderly population.

- In FY 2001, CSAP will conduct a Mentoring and Family Strengthening Dissemination program, which will build upon the success of its Project Youth Connect (mentoring) and Family Strengthening programs, which have developed scientifically proven prevention practices for high risk youth. The dissemination program will extend these programs to wider settings, including workplaces, schools, recreational centers, shelters, and other community settings, and to other populations. It will also involve the faith community as a major provider of prevention services in local communities.

- CSAP will continue to provide funding for Minority Substance Abuse and HIV Prevention. The FY 2001 funding will support three types of grants: planning grants for community organizations to establish coordinated HIV/substance abuse prevention programming; expansion grants for community organizations already providing some services, and

cooperative agreements to faith-based organizations to collaborate with other organizations serving youth.

S Finally, in FY 2001, CSAP proposes funding approximately 8 new State Incentive Grants, bringing the total to 37. Funding will enable States to examine their State prevention systems and redirect State resources to critical targeted prevention service needs within their State. This expansion is consistent with CSAP's goal of establishing a SIG grant in every State.

S A total of $49.7 million is available from the Substance Abuse Prevention and Treatment Block Grant set-aside and $12.0 million from Program Management earmarked funds for Goal 1 activities related to data collection, administered by the Office of Applied Studies (OAS).

S The authorizing legislation of SAMHSA requires the annual collection of data on the national incidence and prevalence of substance abuse, emergency room admission due to a substance abuse problem, and the characteristics and costs of treatment facilities and the number and characteristics of individual in treatment. These data are obtained in three major surveys: (1) the National Household Survey on Drug Abuse (NHSDA); (2) the Drug Abuse Warning System (DAWN); and (3) the Drug and Alcohol Services Information System (DASIS). These surveys are the only source of national data on the extent of substance abuse in the general population and the nature of the treatment system. They also provide information critical to evaluating the success of federal and substance abuse programs.

Goal 3: Reduce health and social costs to the public of illegal drug use.

A total of $902.9 million (including $22.8 million in treatment set-aside funding) is available for Goal 3 treatment activities from the Substance Abuse Prevention and Treatment Block Grant. Activities supported through the Block Grant treatment funds include:

- Funding distributed to the 50 States, 8 Territories, the District of Columbia, and the Red Lake Band of Chippewa Indians for prevention and treatment of the use of alcohol and other drugs. SAMHSA's latest estimate projects that a total of 2.9 million persons with severe drug abuse problems did not receive treatment in 1998. This represents a 19% decrease in the gap from 1997, and growth in the SAPT Block Grant allows significant infusions of Federal funds to leverage State, local, third party and other resources to develop effective systems of care. The SAPT Block Grant funding supports about 51% of all publicly funded treatment and will provide services for approximately 337,000 in 2001.

- CSAT's $22.8 million from the SAPT Block Grant set-aside funds a variety of technical assistance activities requested by the States, the conduct of treatment needs assessments on a cyclical basis for the States and Territories, and performance of treatment program evaluations. In 2001, $5.0 million from the set-aside will be devoted to the continuing development of a National Treatment Outcomes Monitoring System (NTOMS).

A total of $256.1 million is available for Goal 3 treatment Programs of Regional and National Significance, as follows:

- CSAT will fund approximately 357 grants and contracts ($160.9 million) for Targeted Capacity Expansion projects which focus on development of creative and comprehensive drug and alcohol early intervention and treatment systems for adults and adolescents in small towns, rural areas, and mid-size cities. In addition to youth, other populations targeted by this program would include women, homeless, co-morbid, rural populations, poly-substance abusers, and persons re-entering into society from the criminal justice system. Included as a key component of the targeted capacity program is a $56.8 million effort focusing on enhanced and expanded substance abuse treatment services related to HIV/AIDS in African-American, Hispanic and other racial/ethnic minority communities. New in 2001 will be a $10.0 million effort targeting homeless persons with substance abuse problems. Also new is a jointly-funded project with CMHS, the Department of Labor, and the Department of Justice to develop a comprehensive, multi-agency approach to providing substance abuse and mental health services, job training and placement, and supervision to juveniles and adults returning *(Re-Entry)* to the community and their families from prison, jail, or detention centers.

- CSAT will fund approximately 348 grants and contracts ($95.3 million) supporting knowledge development and application efforts bridging research to practice so that treatment programs are effective and efficient, represent best practices, and can be held accountable by evaluation against established standards, performance measures, and outcomes. These programs address: access, inter-system linkages, infrastructure, and treatment quality improvement; family and community support and reduction of stigma; regulation, accreditation, and technical assistance for opioid addiction treatment programs; community health centers for migrant workers; early childhood intervention; addiction technology transfer; and expansion of treatment incorporating the knowledge and skills of faith-based organizations.

2002 Request

- A total of $1.755 billion is requested for the drug abuse budget in FY 2002, an increase of $99.6 million over 2001. The increase includes: $40.0 million for treatment Programs of Regional and National Significance; $42.6 million, from the Substance Abuse Prevention and Treatment Block Grant; and $29.0 million from DHHS 1% evaluation resources for data collection, which is partially offset by elimination of the $12.0 million in Program Management funding that had been earmarked for the National Household Survey on Drug Abuse (NHSDA) in 2001.

<u>Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.</u>

CSAP proposes the following program expansions/new efforts in support of Goal 1 in FY 2002:

- Community Initiated Program ($5 million). CSAP intends to award an additional 20 new community initiated grants in FY 2002.

- CSAP will also continue to support prevention interventions in early childhood through its Strengthening Early Interventions by Integrating Behavioral Health Services program ($2.5

million), an extension of its successful Starting Early/Starting Smart (SESS) program. The *SESS* program is a unique public/private collaboration to test the effectiveness of integrated mental health and substance abuse prevention and treatment services for children up to seven years old and their parents and caregivers. Early results show positive trends in physical health, behavior, and social and emotional functioning, as well as improved collaboration across private and public agencies. The Strengthening Early Interventions will expand and integrate the most promising and successful SESS strategies and methods in new venues such as Early Head Start and faith-based early childhood programs. This effort builds on recent compelling brain research identifying the early years of life as a critical time for growth and development.

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- State Incentive Grants ($10 million): CSAP intends to award an additional 3 SIG grants in FY 2002, for a total of 40 states having received support.

- Minority Substance Abuse and HIV Prevention ($13million): CSAP will continue to support grants to address the problems of substance abuse and HIV in minority communities. Organizations which received planning grants to develop their community infrastructure in FY 2001 will be eligible for grants to provide integrated substance abuse and HIV prevention services.

- National Data Collection ($29.0 million), supports the evaluation of what works for whom; examining what makes quality care; and determining whether needs and services are good fit. Overall, SAMHSA through its data analysis and information gathering programs is identifying trends and ways to respond to them in a proactive manner, and measuring the performance of federal, state, and local services efforts.

Goal 3: Reduce health and social costs to the public of illegal drug use.

CSAT proposes the following program expansions/new efforts in support of Goal 3 in FY 2002:

- Programs of Regional and National Significance ($40.0 million): This increase is requested to fund approximately 54 new discretionary grants, providing treatment services proven to be effective in reducing abuse for approximately 12,000 persons. Resources will be focused on high-risk populations and high-need communities. These funds will support a variety of targeted capacity expansion programs, as follows:

  – A treatment services project for teens and young adults, providing both residential and outpatient treatment ($14.0 million);

  – Expanded treatment capacity to support adult and juvenile justice and family Drug Courts ($10.0 million);

  – Re-Entry Programs for adolescents returning from detention facilities to the community ($6.0 million);

  – Treatment programs for the homeless ($4.0 million); and

– Targeted capacity expansion programs for the general population ($6.0 million).

– The total PRNS discretionary funding program in FY 2002, including the new efforts described above, will total $296.1 million and will be comprised of approximately 526 grants serving an estimated 95,000 persons.

- The SAPT Block Grant will be increased by $60.0 million, of which $42.6 million will be dedicated to treatment of drug abuse, including alcohol-related drug use (co-morbid use) and use of alcohol by underage persons. States have the opportunity to direct resources to the particular substance abuse problems and geographic regions of greatest need, and to a variety of community-based organizations. We estimate that the total number of persons served through SAPT Block Grant funded programs in 2002 will exceed 342,000.

V. PROGRAM ACCOMPLISHMENTS

National Treatment Plan (NTP). One of CSAT's major accomplishments in 2000 was the roll-out of the NTP, a project that builds on recent advances in the field, to bring together the best ideas about improving treatment, and to identify action recommendations that could translate ideas into practice. The NTP combines the recommendations of five Expert Panels, with input from six public hearings and solicitation of experience and ideas through written and online comments, into a five-point strategy: (1) Invest for Results; (2) No Wrong Door to Treatment; (3) Commit to Quality; (4) Change Attitudes; and (5) Build Partnerships. The recommendations represent the collective vision of the participants in the NTP "conversation" over the past year. The goal of these recommendations is to ensure that an individual needing treatment—regardless of the door or system through which he or she enters—will be identified and assessed and will receive treatment either directly or through appropriate referral. Systems must make every door the right door.

The NTP was officially released to the Nation during a two-day event in late November, 2000. A constituency briefing was held on November 27, during which CSAT leadership, along with the Chairs of each of the five NTP panels briefed an eager audience on the details of the recommendations of the NTP. The following day, a news conference was held at the National Press Club, to officially roll out the National Treatment Plan to the Nation. The newly appointed Executive Director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), Dr. Lewis Gallant, pledged the full support of NASADAD in the implementation of all the NTP recommendations. Personal experiences and words of support for the NTP were heard from William Cope Moyers, President, Johnson Institute Foundation; a young man in recovery who testified at the Washington, DC, Public Hearing; and the mother of an adolescent substance abuser who testified at the Hartford, CT, Public Hearing. The NTP events were both well attended and well received. Additional information on the NTP can be found at www.natxplan.org/.

Satellite Downlink Tele-conference for Recovery Month 2000. Throughout September, 2000, CSAT and its partners sponsored Recovery Month 2000, the theme of which was "Recovering Our Future: One Youth At A Time." As part of the monthly activities, on September 14, 2000, a satellite downlink hosted by the Community Anti-Drug Coalitions of America (CADCA), with support from the Multi-jurisdictional Counterdrug Task Force Training Program, was viewed in 252 sites. Downlink sites were located in 44 States with 2 additional sites in Canada and 1 each in the District

of Columbia and Bermuda. Approximately 37 public access stations carried the downlink with an estimated audience of 1,831,700 households. This topic was clearly of interest to organizations that serve youth. The 1,044 schools and 28 school districts tuning in received critical information that will help them to better serve youth in their communities.

Cannabis Youth Treatment (CYT). Findings from this CSAT cooperative agreement program were released in November, 2000. Leading academic researchers and community based treatment providers participated in this project, which involved the manualization of five existing and promising approaches to outpatient treatment for marijuana using adolescents. Six hundred adolescents and their families were recruited from four sites (two major medical centers and two major community based providers) and then randomly assigned to one of five types of treatment varying in theoretical orientation, mode of delivery, duration, and degree of involving families.

It was noted that all five treatments studied were significantly better then evaluations of existing practice. Prior to the CYT Study, 80% of adolescents treated in outpatient settings had post-treatment outcomes ranging from decreasing use by 15% to increasing use by 10%. The CYT Study reported decreasing use an average of 31% between the three months before and after treatment. While there were some small significant differences by condition (e.g., the most expensive and/or extensive treatment did better), these varied by site, time and outcome and paled in comparison to the improvement of all five over existing practice. The average weekly economic costs of the five types of outpatient treatment ranged from $105 to $244 per adolescent. Findings from the project are posted at www.chestnut.org/li/CYT and copies of the five treatment manuals will be available from CSAT at www.samhsa.gov/centers/CSAT in spring/summer 2001.

National Expenditures For Mental Health and Substance Abuse Treatment, 1997. On July 17, 2000, SAMHSA held a press conference at which the new estimates of national expenditures for substance abuse and mental health treatment were released. Overall, national expenditures for treatment of mental illness and abuse of alcohol and illicit drugs totaled $82.2 billion in 1997. Of this total, eighty-six percent ($70.8 billion) was for treatment of mental illness, and fourteen percent ($11.4 billion) was for treatment of alcohol and drug abuse. This health care spending report, co-funded by CSAT and the Center for Mental Health Services (CMHS), has been extremely well-received and the data are being used throughout the mental health and substance abuse treatment provider communities, as well as by many individuals in the general health care field. Additional analyses are now being conducted for children vs. adults vs. elderly to learn more about how treatment expenditures are divided among these groups. This information is planned for inclusion in updates to the study. More information about can be found at www.samhsa.gov.news/.

Rulemaking on Opioid Agonist (Methadone/LAAM) Treatment. On January 17, 2001, new federal regulations were issued to improve the quality and oversight of substance abuse treatment programs that use methadone and other medication to treat heroin and similar addictions. The regulations create a new accreditation program to be managed by CSAT and replace a 30-year-old inspection program conducted by the Food and Drug Administration (FDA). The new program mirrors the recommendations that have been made over the last decade by several groups, such as the Institute of Medicine, the General Accounting Office, and the National Institutes of Health. Under the rule, substance abuse treatment programs using methadone or Levo-Alpha-Acetyl-Methadol (LAAM) would be accredited by non-federal agencies in accordance with standards for methadone treatment

programs that have been developed by CSAT in concert with the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The standards are state-of-the-art, are based on best practice guidelines developed by CSAT over the past 10 years, and emphasize improving the quality of care, such as individualized treatment planning, increased medical supervision, and assessment of patient outcomes.

Accreditation has been proven over the years to produce effective outcomes and is a widely adopted external quality assessment system used by the federal government, states, managed care firms, insurers, and others to ensure accountability for quality treatment. Accreditation should give assurances to communities that the highest quality medicine is being practiced. The new regulations strike a balance between patient benefits and community concerns, and reflect the consideration of approximately 200 comments submitted in response to the proposed rule which was published in July, 1999. When the regulations take final effect, the existing FDA regulations will be rescinded; however, regulations of the Drug Enforcement Administration (DEA) regarding diversion of methadone will remain in place. The final rule includes a "transition plan" that allows existing treatment programs approximately 2 years to achieve accreditation under the new system.

CSAP's High Risk Youth Cross-Site Evaluation yielded significant findings about the effectiveness of various substance abuse prevention interventions, including:

- Youth who had already started using cigarettes, alcohol, and marijuana reduced their use after entering the program;

- Substance abuse outcomes were more positive for males than for females at the program's end, but positive outcomes emerged later and lasted longer for females;

- More than two thirds of the programs reduced substance abuse and/or strengthened factors shown to protect against use; and,

- Life skills training was more effective than education about drugs and alcohol.
  CSAP is disseminating these results, which are expected to shape future prevention efforts at the federal, state, and local levels.

Youth Drug Use Decreases- SAMHSA's recently-expanded National Household Survey on Drug Abuse found that illicit drug use has declined among youth, ages 12-17, in the period 1998-99. The trends are consistent with the findings of the annual Federal Monitoring the Future Study as well as other studies. Rates of first use are an important predictor of future rates of drug use, and the numbers for adolescents are pointing in the right direction. For the first time since the late 1980's, a statistically significant decline has been reported in the rate of young people, ages 12-17 who report trying marijuana for the first time. After years of increases, the rate of first use for cocaine, inhalants, hallucinogens, and heroin is level or dropping.

Estimates of Number of Persons Needing and Receiving Treatment for Drug Abuse Problems
NHSDA 1991-98

	Number of Persons (in 1,000's)

	1991	1992	1993	1994	1995	1996	1997	1998
Total Drug Abuse Treatment Need	8,991	8,599	8,067	8,329	8,906	9,383	9,474	8,993
Level 1 Treatment Need *								
Persons with Less Severe Problems Needing Treatment	3,843	3,881	3,326	3,719	4,260	4,080	3,748	3,962
Level 2 Treatment Need *								
Persons with Severe Problems Needing Treatment	5,148	4,718	4,741	4,610	4,646	5,303	5,726	5,031
Persons Receiving Treatment	1,649	1,814	1,848	1,984	2,121	1,973	2,137	2,137
Percent of Level 2 Treated	32%	38%	39%	43%	46%	37%	37%	43%
Percent of Level 2 Not Treated	68%	62%	61%	57%	54%	63%	63%	57%
Treatment Gap	3,499	2,904	2,893	2,626	2,525	3,330	3,589	2,894

* The need for treatment varies according to the severity of the problem. To reflect these differences, HHS divided those needing treatment into two categories, termed Level 1 and Level 2, based on intensity of drug use, symptoms, and consequences. The more severe category of need is Level 2, meaning the severity of symptoms make these users prime candidates for treatment. Level 2 users correspond to chronic, hardcore users discussed in the National Drug Control Strategy.

Note: Estimates for 1991-98 are ratio-adjusted to partially account for underestimation due to underreporting and undercoverage in the NHSDA. Estimates for 1991-93 are also adjusted for trend consistency, to account for the change in the NHSDA questionnaire in 1994. Adjustment factors for trend consistency were 1.19020 for total treatment need and 1.21125 for Level 2 treatment need.

Due to improvements in coverage in the Uniform Facility Data Set (UFDS) in 1998, UFDS counts of clients in treatment are not comparable to earlier counts. Therefore, the 1997 estimate of number treated was used to estimate treatment gap in 1998. This methodology is currently being reviewed by an interagency working group. Treatment need is to be defined based on estimating those diagnosed with drug abuse or dependence according to DSM-IV criteria.

Source: Office of Applied Studies, SAMHSA. Unpublished data from the National Household Survey on Drug Abuse and Uniform Facility Data Set (1991-1998).

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Number of Persons Receiving Treatment with SAMHSA Funding

(Treatment Funding Dollars in Thousands)

	2000 Actual	2001 Enacted	2002 Request	Increase 2002 vs 2001	% Increase 2002 vs 2001
SAMHSA Drug Treatment Funds (000's)	$973,524	$1,053,843	$1,123,483	+$69,640	+6.6%
Average Cost--Per Person/Per Year*	$2,445	$2,504	$2,557	+$53	+2.1%
Persons Served w/SAMHSA Funds	398,169	420,864	437,411	+16,547	+3.9%
Programs of Regional and National Significance	*67,199*	*83,474*	*95,217*	*+11,743*	+14.1%
SAPT Block Grant Programs	*330,970*	*337,390*	*342,194*	*+4,804*	+1.4%

* FY 2002 factored cost for $8 million in adolescent residential treatment is $6,960 per person.

Substance Abuse and Mental Health Services Administration
HIV/AIDS Related Activities

Overview

Reports on cumulative adult AIDS cases through June 2000 indicate that 36 percent of new HIV cases are directly or indirectly related to injecting drug use and 50% are related to overall substance abuse. This underscores the urgency in addressing the dual epidemics of substance abuse and HIV/AIDS. Current estimates suggest that there are 13 million to 16 million substance abusers in this country. The National Institute on Drug Abuse estimates that there are approximately 1.5 million injecting drug users, many of whom are multiple drug users. In addition, the sexual partner(s) and unborn children of injecting drug users are at great risk of exposure to HIV infection. Of newly diagnosed adult/adolescent cases of AIDS between July 1999 and June 2000, 29% were directly attributable to injection drug use (IDU). However, among minority men the percentage of IDU related AIDS cases was 32% while among minority women the percentage of IDU- related AIDS cases was 35%.

The epidemiology of HIV/AIDS in communities of color continues to be a severe and a ongoing crisis that remains virtually unchecked, especially among African Americans and Hispanics. The burden of HIV/AIDS on racial and ethnic minorities is exacerbated by drug use and remains an ongoing crisis that requires both immediate measures and a long term sustained commitment to overcome. According to the Centers for Disease Control and Prevention (CDC), AIDS is now the leading cause of death among African Americans, ages 25 to 44. Racial and ethnic minorities together account for more than 54% of the total AIDS cases reported since the beginning of the epidemic. Latinos account for 18% of the total AIDS cases.

The number of cases of HIV among the substance abusing populations is quite evident -- injection drug use accounts for approximately 57 percent of the reported AIDS cases among women; 52 percent of the reported pediatric AIDS cases; and 31 percent of the total male AIDS cases. However, these figures understate the overall impact of the use of "mood-altering substances" because of the large number of AIDS cases related to alcohol and other non-injection drug use (including crack cocaine use). The use of mood-altering substances, and mental illness, both independently and in combination greatly increases an individual's likelihood of engaging in unsafe sex practices, including having multiple sex partners that can lead to the transmission of HIV.

The impact of HIV on the mental health status of persons living with HIV/AIDS is of critical concern to SAMHSA. To date, more than 711,000 AIDS cases have been reported in the United States, and current CDC estimates suggest that there are 600,000 to 900,000 people infected with the virus. An additional 40,000 new HIV infections occur every year. The current public mental health system in this country does not have the capacity to meet all the mental health needs of those infected with the HIV; much less those affected by HIV and AIDS. It is important that services addressing the needs of this population be enhanced.

Since its inception in 1992, SAMHSA has supported HIV/AIDS-related activities through its Centers. SAMHSA's Center for Mental Health Services (CMHS) has supported a portfolio of projects, designed to educate and train traditional and non-traditional mental health care providers to address

the mental health needs of HIV/AIDS infected persons and those at risk for HIV infection. More than 150,000 mental health care providers have received specialized training supported by the CMHS program.

SAMHSA's Center for Substance Abuse Treatment (CSAT) has supported HIV/AIDS-related activities through demonstration programs and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. States whose AIDS case rate is 10 or more per 100,000 population are required to expend 2-5 percent of the Block Grant to establish one or more projects to make available HIV/AIDS early intervention services at substance abuse treatment sites. In FY 2000, the HIV set-aside amounted to approximately $54.2 million. In addition, SAMHSA's Center for Substance Abuse Prevention (CSAP) has supported HIV prevention activities targeting high risk adolescents through its High Risk Youth Program.

SAMHSA has been increasingly involved in addressing the interconnected epidemics of substance abuse and HIV/AIDS. In August 1996, SAMHSA along with other Federal agencies and national organizations co-sponsored a forum to bring substance abuse and HIV/AIDS policy makers, and service providers together to improve collaboration and integration of substance abuse and HIV prevention. In addition, SAMHSA's Office on AIDS convened a group of experts from the field to assist in the development of effective plans to ensure that substance abuse prevention and treatment, and mental health are fully integrated with HIV/AIDS prevention strategies. The Group also recommends Knowledge Development and Application (KDA) study questions in the area of HIV/AIDS as it relates to substance abuse prevention and treatment, and mental health. In 1997, SAMHSA co-sponsored national organizations HIV/AIDS conferences, i.e., the Latino Lesbian and Gay Organization (LLEGO), the United States Conference on AIDS, and Men Who Have Sex with Men Conference. SAMHSA's participation in these most significant conferences will not only improve collaboration efforts, but also encourage information sharing and data gathering and linkages for SAMHSA's activities and development of a strategic plan for HIV/AIDS.

In 1998, SAMHSA supported a project of the National Association of State and Territorial AIDS Directors (NASTAD) in collecting data on how the states are collaborating around issues relating to HIV/AIDS and substance abuse. Because the majority of the AIDS cases among African American women and children are directly or indirectly attributable to alcohol and other drug use, SAMHSA has also supported the National Minority AIDS Council (NMAC) in gathering data to assist SAMHSA policy and program staff in developing future strategies to address the special needs of women with HIV/AIDS.

SAMHSA has played a major role in the development of the HHS response to the Congressional Black Caucus (CBC). SAMHSA staff have participated in all facets of the CBC activities. These processes have built stronger linkages and collaboration among SAMHSA and include HRSA, CDC, NIH, and the Office of Minority Health.

In FYs 1999 and 2000, SAMHSA was provided $22 million and $48 million respectively for the comprehensive substance treatment and prevention programs for certain minority populations at risk for HIV or living with HIV/AIDS. These include substance abusing African American and Hispanic men (including men who have sex with men), women, and young people. The Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention were designated to administer the

CBC funded activities. In FY 2001, SAMHSA was provided $92.1 million for the Congressional Black Caucus HIV/AIDS activities for minorities. Of this amount $7 million was for CMHS, $32.1 million for CSAP, and $53 million for CSAT.

SAMHSA continues to be committed to developing and implementing a response that both maximizes the effectiveness of existing programs to serve racial and ethnic minority communities confronting HIV/AIDS and substance abuse and mental disorders, and developing new and innovative strategies that target assistance to address specific needs. With more cases attributable to injecting drug use among African Americans, efforts to stop HIV transmission must include substance abuse prevention and treatment programs and mental health support services as part of the array of strategies being offered.

Mental Health Services

The *Mental Health Services Demonstration Program* was a collaborative effort of SAMHSA, CMHS, HRSA, and NIH. It was the first Federal effort to develop models of delivery of mental health services to people living with and/or affected by HIV/AIDS. This program has shed new light on how to develop services and develop systems of care. Findings from the program indicated that early intervention with mental health services can improve adherence to medical and other treatments. Mental health treatment services and HIV education play an important role in preventing children and adolescents whose parents have HIV or AIDS from acquiring the virus themselves.

The *HIV/AIDS High-Risk Behavior Prevention/Intervention Model for Young Adults/Adolescents and Women Program* is a collaborative venture aimed at bringing AIDS prevention into the community. Project SHIELD also represents an opportunity to move the field of HIV prevention research forward along the two parallel continuums of innovative intervention design and rigorous evaluation. The multisite nature of this HIV prevention trial has the potential to test the efficacy of two similar brief behavioral interventions and generalize the study results to more than one study population. In essence, the question posed by Project SHIELD is: can the principles underlying effective HIV prevention interventions be applied in brief formats to real world clients and still be effective in reducing HIV risk behaviors? Although the HIV prevention field has traditionally relied on self reports of risk behaviors as the primary outcome, Project SHIELD will not only measure participants' self reported behavior change, which may be biased, but will *actually* measure reductions in diseases; diseases such as common STDs that are associated with considerable adverse sequelae and may facilitate HIV transmission. Results from this program are expected within the next eighteen months.

The *HIV/AIDS Mental Health Care Provider Education Program* completed its final year of funding in FY 1998. The program was created to evaluate the dissemination of knowledge on (1) the psychological and neuropsychiatric sequelae of HIV/AIDS, and (2) the ethical issues in providing services to people with HIV/AIDS, and (3) the relative effectiveness of different education approaches. Training approaches are incorporating the most current research-based information and allow easy modifications to reflect changes in the medical regimen for treatment of AIDS.

The *HIV/AIDS Treatment Adherence/Health Outcome and Costs Study* reflects the collaboration of six Federal entities—the Center for Mental Health Services, which has lead administrative

responsibility; the Center for Substance Abuse Treatment; the HIV/AIDS Bureau in the HRSA; and the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, all components of NIH. It is the first-ever Federal initiative designed to study integrated mental health, substance use, and primary medical HIV treatment interventions and to determine if an integrated approach to care improves treatment adherence, produces better health outcomes, and reduces the overall costs associated with HIV treatment.

In FY 2001, Congress appropriated $7 million to CMHS as part of the *Congressional Black Caucus' programs for HIV/AIDS* for the treatment of mental health disorders related to HIV disease including: dementia, clinical depression and the chronic, progressive neurological disabilities that often accompany HIV disease. These direct services grants will be awarded to community-based providers that operate in traditional and non-traditional settings. In addition to the direct service grants there is an additional $2.5 million training component that targets both traditional and nontraditional mental health care providers, and will target primarily the needs of people of color. This $2.5 million came from the Department's Supplemental Emergency Fund

Substance Abuse Prevention

SAMHSA's Substance Abuse Prevention and HIV Prevention program began in 1995. CSAP supplemented twenty of its High Risk Youth grantees to integrate HIV prevention strategies with substance abuse prevention strategies. In 1996, a task force was formed with the Director of CSAP/SAMHSA and Director of Center for HIV, STD & TB/CDC, as co - chairs. This task force convened a historic meeting, the Tampa Forum, with specific recommendations sanctioned by the Administrators of HRSA, SAMHSA and the CDC. The 1999 CBC appropriation included resources for a grant program in CSAP to address the integration of substance abuse prevention and HIV prevention in African American youth, youth of color, women of color and their children.

The Substance Abuse Prevention and HIV Prevention Program for Youth and Women of Color was developed to integrate evidence-based substance abuse prevention strategies with evidence-based HIV prevention strategies for a comprehensive approach. This Targeted Capacity Expansion (TCE) Grant Program was first funded in FY 1999 with $8.5 million from SAMHSA and $5 million from the Secretary's Emergency Fund. Its purpose is to integrate substance abuse prevention and HIV prevention services at the local level and to increase community capacity to provide prevention services to populations disproportionately impacted by HIV disease. Grantees included CBOs, historically Black colleges and universities, Hispanic colleges and universities, faith entities, and other coalitions and/or partnerships.

SAMHSA plans to expand the dissemination of evidence-based models in the Substance Abuse Prevention and HIV Prevention Program (SAP & HIVP) through CSAP's Decision Support System. This on-line database contains numerous science-based models for unique & specific populations.

Effective Community-Based Prevention

- ✓ Program-Specific Technical Assistance
- ✓ Institutional Mentoring
- ✓ Faith-Based and Community-Based Programs
- ✓ Diversified Funding Streams
- ✓ Cross-Trained Health Professionals
- ✓ Competence in Community Development Strategies

SAMHSA will also continue to provide resources to current SAP & HIVP grantees to strengthen their infrastructure and increase the capacity of additional communities of color to provide competent prevention, early intervention, referral and treatment services. The program will enable grantees to train healthcare professionals and clergy to deliver culturally acceptable, family-centered, community based, comprehensive health care services. Finally, to help grantees plan for sustaining these efforts after SAMHSA funding ends, efforts will continue to link this program and its grantees to other federal partners (HRSA, CDC, OMH, etc.).

CSAP's 2001 strategy incorporates lessons learned and targets communities with high sero prevalence and a dearth of prevention services. CSAP's second cohort of grants and resources target Substance Abuse Prevention and HIV Prevention services expansion by 1) planning grants to develop the infrastructure necessary to address the reduction of new cases of substance abuse related HIV infection; 2) continuing our core program which integrates substance abuse prevention and HIV prevention and a special new program for faith-based organizations to expand their youth service delivery in collaboration with youth serving organizations; and 3) expanding our core program to integrate primary health care services with substance abuse and HIV prevention services. These programs and activities will outreach to and serve approximately 500,000 persons, nationwide through a total of 114 grants funded by CSAP.

CSAP's 2002 activities uses established CSAP programs, models, and networks to expand integrated HIV prevention/substance abuse prevention services in high risk communities. A two-phase $13 million effort will concentrate on institutionalizing integrated substance abuse and HIV prevention services through the established prevention infrastructure of SIGs and CAPTs to further target those communities with high sero prevalence and minimal prevention services. Emphasis will be placed on training community residents to provide intensive outreach services to these very hard-to-reach populations. The second component will address the training needs of health professionals in integrating substance abuse and HIV prevention. This is a critical need in the comprehensive strategy aimed at the health emergency in communities of color, especially in light of the Administration's plan to increase the number of community health centers in these underserved communities.

Substance Abuse Treatment

In FY 1999, as part of the CBC activities CSAT received $16 million to address the crisis that exists of *HIV/AIDS in the Black Community* as highlighted by members of the Congressional Black Caucus (CBC). In response to this issue and the increasing number AIDS case rate among racial and ethnic minority populations, CSAT awarded 36 Targeted Capacity Expansion/HIV grants to community-based organizations to augment, expand and enhance substance abuse treatment services, HIV/AIDS and infectious disease services. In addition, CSAT also funded 25 HIV Outreach Projects that were designed to target hard-to-reach, high-risk substance abusers with prevention and behavioral risk information and to facilitate their early entry into substance abuse treatment. These grants were restricted to metropolitan areas with AIDS case rates of 20 per 100,000 or higher and States with AIDS case rates of 10 or more per 100,000 (as reported in the CDC's HIV/AIDS Surveillance Report). These funds were earmarked for comprehensive substance abuse treatment programs for substance abusing African American and Hispanic populations at risk of contracting HIV, including women and their children and men who have sex with men.

CSAT continued the agenda set by the Congressional Black Caucus in FY 1999 which was expanded with the FY 2000 appropriation. Further expansion of the HIV/AIDS activities in African American, Hispanic and other ethnic/racial minority communities is planned in FY 2001 for a total of $53 million. Approximately 12-15 new Targeted Capacity Expansion/HIV grants will be awarded. These new grants will further expand efforts begun by the Congressional Black Caucus in FY 1999, focusing on enhanced and expanded substance abuse treatment services related to HIV/AIDS in African-American, Hispanic and other racial/ethnic minority communities. CSAT will continue this program in FY 2002.

Significant performance has been achieved to date with the Targeted Capacity Expansion/HIV grants; approximately 4,301 clients/projects have been served. Preliminary data from the 25 Outreach Grants awarded in year one (FY 2000) indicates that 112,933 clients were reached through face-to-face and group contacts; 5,185 clients received an HIV test; and 2,697 clients were referred to treatment.

Substance Abuse Prevention and Treatment (SAPT) Block Grant HIV/AIDS Activities

Current law requires that 2% - 5% of the block grant allocation must be spent on HIV/AIDS-related substance abuse programs in States with an AIDS case rate of 10 per 100,000 population. This provides an estimated $55.9 million from the total Block Grant funding for FY 2001 and $57.9 million in FY 2002.

HIV/AIDS activities supported with the Secretary's Departmental Management Funds

- SAMHSA will provide $2.5 million to add a training component to CMHS' CBC-related direct service grants. Funding will be provided to community-based organizations to develop model educational approaches to train mental health care providers in substance abuse and HIV care.

- SAMHSA will also provide $4.0 million to develop a new faith-based effort focused on youth in CSAP. The effort will develop leadership roles and will mobilize and build capacity in minority churches and communities.

- SAMHSA will award $5.0 million to extend CSAT's Targeted Capacity Expansion program to support community-based HIV/AIDS treatment services targeted to at-risk African American, Hispanic/Latino, and other racial/ethnic minority communities.

Substance Abuse and Mental Health Services Administration
HIV/AIDS by Functional Category
(Dollars in thousands)

Functional Categories	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate
II. Risk Assessment and Prevention:			
C. Information and Education/Preventive Services:			
1. High risk or infected persons:			
a. Health education/risk reduction	$11,500	$32,600	$32,100
Subtotal, High Risk or Infected Persons	11,500	32,600	32,100
5. Health-care workers and providers	2,634	1,435	1,435
Subtotal, Information and Educ./Preventive Services	14,134	34,035	33,535
Total, Risk Assessment and Prevention	14,134	34,035	33,535
IV. Clinical Health Services Research and Delivery:			
A. Services:			
1. Community and mental health center services	2,346	9,183	11,600
3. Substance abuse treatment improvement program	93,867	110,734	112,748
Subtotal, Services	96,213	119,917	124,348
Total, Clinical Health Services Res. and Delivery	96,213	119,917	124,348
Total, SAMHSA	$110,347	$153,952	$157,883

Substance Abuse and Mental Health Services Administration
HIV/AIDS Activities
(Dollars in thousands)

	FY 2000 Actual	FY 2001 Appropriation	FY 2002 Estimate
Programs of Regional and National Significance:	$55,617	$97,455	$99,372
Mental Health	*(7,980)*	*(11,118)*	*(13,035)*
Substance Abuse Prevention	*(8,500)*	*(32,100)*	*(32,100)*
Substance Abuse Treatment	*(39,137)*	*(54,237)*	*(54,237)*
Substance Abuse Block Grant	54,150	55,917	57,931
Program Management	580	580	580
Total, SAMHSA Funds	$110,347	$153,952	$157,883
Total by Center/Program Management:			
Mental Health Services	$7,980	$11,118	$13,035
Substance Abuse Prevention	8,500	32,100	32,100
Substance Abuse Treatment	39,137	54,237	54,237
Substance Abuse Block Grant	54,150	55,917	57,931
Program Management	580	580	580
Total, SAMHSA	$110,347	$153,952	$157,883

NATIONAL DATA COLLECTION

Authorizing Legislation: Section 505 of the Public Health Service Act

	2000 Actual	2001 Appropriation	2001 Current Estimate	Increase or Decrease	2002 Estimate	Increase or Decrease
Natl Data Coll	---	---	---	---	$29,000,000	+$29,000,000

2002 Authorization ..... Indefinite

Purpose and Method of Operation .....

The availability of incidence and prevalence data on substance abuse is crucial to efforts to reduce the Nation's drug problems, and SAMHSA is the primary source of this information. Three projects provide the basic information on the nature and extent of substance abuse in America and the consequences of Federal, State, and local policies and programs to prevent and treat this problem.

In FY 2002 these projects, managed by the SAMHSA Office of Applied Studies, - the National Household Survey on Drug Abuse (NHSDA), the Drug Abuse Warning System(DAWN) , and the Drug and Alcohol Services Information System(DASIS) - will be supported with funds from the 5% set-aside of the Substance Abuse Prevention and Treatment Performance Partnership (authorized by Section 1935 of the PHS Act) and the 1% evaluation set-aside (authorized by Section 238j. of the PHS Act).

In FY 2002 appropriation language has been added to SAMHSA to transfer $29.0 million from 1% evaluation resources available to the Department under the Authority of Section 241 of the Public Health Service Act. These resources will be used to augment resources provided by the block grant set aside.

The National Household Survey on Drug Abuse (NHSDA) is the principal source of statistical information on the use of legal and illegal drugs by the civilian, non-institutionalized population. The current survey has a sample of 70,000 persons 12 years and older who are interviewed in their residence. The sample has been designed to provide both national and State estimates on the prevalence and incidence of substance abuse; treatment sought or received for substance abuse problems; and the behavior, personal characteristics, and attitudes of those who use substances.

In recent years the questionnaire has been modified to collect information on tobacco use, mental health status of adults, the market for marijuana, and the source and cost of mental health and substance abuse treatment. Included, as well, is a validity study using chemical tests to show the proportion of respondents who give truthful answers to drug use questions.

DAWN is an important source of national and local data on substance abuse. The data are obtained from medical records of visits to hospital emergency departments (EDs) and from reports of drug-related deaths provided by medical examiners. DAWN contains information on the demographic characteristics of substance abusers and the specific drugs involved in each drug-related ED visit or death. The detailed data acquired on specific drugs are not duplicated in any other data system.

DAWN data are used for many purposes: (1) monitoring trends in major substances of abuse such as heroin, cocaine and marijuana; (2) identifying the emergence of new drugs of abuse such as Ecstasy and methamphetamine; (3) identifying the abuse potential of prescription or over-the-counter drugs to assist in scheduling and labeling decisions; and (4) observing changing patterns of drug abuse in local communities.

DASIS is the only source of national data on substance abuse treatment services and the characteristics of individuals admitted for treatment. The project is based on three data sets: (1) The Inventory of Substance Abuse Treatment Services (I-SATS) lists all substance abuse treatment providers known to SAMHSA; (2) the National Survey of Substance Abuse Treatment Services (N-SSATS) collects information from all providers listed in I-SATS on facility characteristics, services offered, and number of clients in treatment; and (3) the Treatment Episode Data Set (TEDS) contains client-level information, including demographics and drug history, on admissions to treatment facilities that receive public funds. N-SSATS provides the basis for the on-line Substance Abuse Treatment Facility Locator (http://findtreatment.samhsa.gov). Individuals seeking treatment can find facilities in their area with services consistent with their particular needs.

Rationale for the Budget Request . . . . . .

1. National Household Survey on Drug Abuse (NHSDA) (+$7.5M)

Two new components are proposed for FY 2002:

A. Longitudinal Survey of Youth: ($6.5M) The NHSDA has been invaluable in providing a picture of drug use in this country, but cross-sectional data can suggest but not conclusively define the factors associated with the development of substance abuse problems and the evolution of the disease. Longitudinal data could provide this information and a basis for developing more effective prevention strategies.

To obtain longitudinal data, a sample of 6000 youth, possibly as young as 9 years of age, will be identified during the regular NHSDA interviews and will be interviewed each year until they reach age 25. Additional panels will be added to increase the samples for each age cohort. The NHSDA provides an efficient way to approach this issue and would make it possible to target characteristics of interest, such as income, race and ethnicity.

B. Special NHSDA Survey of the Elderly: ($1.0M) The NHSDA will also be used to examine the problem of substance abuse in older populations. Under SAMHSA's authorizing legislation, the Agency must promote and evaluate substance abuse service requirements for an aging population.

Substance abuse in this group is a poorly understood problem, but conservative estimates suggest it will become a serious problem in the future. By the year 2020, when nearly 80 million baby boomers will be age 65 or older, as many as 5 million of this group could be in serious need of treatment for substance abuse.

The NHSDA provides an efficient way to study this problem. The survey now screens roughly 30,000 households with at least one resident over age of 65. Beginning in January, 2003 the sample will be modified by adding 2000 respondents to the approximately 4400 currently in the survey who are 55 years and older. A special module will be developed to examine the nature of abuse in this population.

2. Drug Abuse Warning System(DAWN) (+$6.2M)

Although there have been vast changes in the health care delivery system, DAWN has changed little since it was initiated by the Drug Enforcement Administration (DEA) in 1972. To make DAWN a more effective source of information, SAMHSA plans to make dramatic changes in DAWN's design beginning in FY 2002:

A. Expand the Sample of Emergency Departments to reflect 45 Metropolitan Areas: DAWN is best at supplying information at the local level, but the 21 metropolitan areas covered by DAWN have remained the same despite changes in the Nation's population. Expanding the metropolitan base and incorporating suburban as well as urban hospitals will substantially increase information available at both the national and the local level and assist ONDCP and the DEA in allocating resources for interdiction and diversion control.

B. Establish a Sentinel Hospital System for Early Reporting: This approach will make the "warning" in DAWN's name a reality. To implement this strategy, a group of hospitals will be added to the sample that can provide leading indicators of emerging drug problems. These hospitals will obtain and transmit information on changes in the substance abuse problem in communities on a real time basis.

C. Change the Criteria for Identifying a DAWN Case: The inclusion of adverse drug reactions from prescription and over-the-counter drugs taken as directed, for example, will help DAWN better meet the needs of the FDA.

D. Convert from Paper to Electronic Forms: One of the major changes in DAWN will be a conversion from paper to electronic forms. This approach will reduce the burden on hospitals, improve data quality, and substantially increase the timeliness and, therefore, the utility of DAWN data for the local communities.

3. Drug and Alcohol Services Information System (DASIS) (+$3.3M)

To address two major problems, the following additions will be made to the DASIS project:

A. Survey of Treatment Services in Correctional Facilities: The absence of information on substance abuse treatment programs in prisons, jails and juvenile correctional facilities has been a serious problem. In 1997, SAMHSA at the request of the Office of National Drug Control Policy(ONDCP) conducted a special survey of treatment services within correctional facilities. That survey identified 2,700 correctional facilities providing on-site substance abuse treatment to a total of 173,000 inmates. Jails and prisons have become a major source of treatment and an important component of any demand reduction strategy.

The new survey will be a biennial addition to – SSATS. Because incarcerated substance abusers may have severe levels of dependence requiring intensive interventions, this survey will include questions that explore intensity of treatment and completion rates. Combining this survey with the on-going N-SSATS, will provide a cost efficient way to obtain information from correctional facilities and facilitate comparisons with general outpatient care.

B. Include a special, periodic survey on the costs of providing treatment. Collecting information on the costs of substance abuse treatment as a routine part of the N-SSATS is not effective. To deal with this problem, DASIS will include a special survey based on a stratified sub-sample of treatment facilities. This special survey will be focused and directed to facility respondents more likely to be familiar with the financial aspects of treatment. Improved data in this area are essential since treatment costs are used for estimating the treatment gap, deciding how to allocate resources, and evaluating the cost effectiveness of treatment programs and activities.